AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

2019 AMA MSS Interim Meeting Manchester Grand Hyatt and Marriott Marquis, San Diego November 14-16, 2019

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Medical Student Section
2019 Interim Meeting Agenda

Thursday, November 14, 2019

ALL MSS Events on Thursday will be in the Manchester Grand Hyatt

Orientation to the AMA and MSS Assembly **3 – 4 pm**
Harbor A-C and Corridor 1

General Assembly **4 – 7 pm**
Harbor A-C and Corridor 1

Region Meetings **7 – 9 pm**

Region 1	Harbor D
Region 2	Harbor E
Region 3	Harbor F
Region 4	Harbor G
Region 5	Harbor H
Region 6	Harbor I
Region 7	Torrey Hills

Friday, November 15, 2019

ALL MSS Events on Friday will be held at the Marriott Marquis

Delegate Credentialing **7 – 8 am**
San Diego Ballroom

Candidate Forum **7 – 8 am**
San Diego Ballroom

General Assembly **8 – 10 am**
San Diego Ballroom

Educational Program: Managing Gender Bias in Medical Careers **8 – 8:45 am**
La Costa Room

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Educational Program: Adverse Childhood Experiences and Trauma Informed Care for Migrant Populations and Displaced People — **8:30 – 9:15 am**
Coronado Room

Educational Program: Case Demonstrations Regarding Women's Health Care with Limited Resources — **9 – 9:45 am**
La Costa Room

Region Meetings — **10 am – Noon**

Region 1	Cardiff
Region 2	Del Mar
Region 3	Carlsbad
Region 4	Miramar
Region 5	Mission Hills
Region 6	Palomar
Region 7	Balboa

Standing Committees Meet and Greet — **Noon to 1 pm**
San Diego Ballroom

Delegate Credentialing — **12:30 – 1 pm**
San Diego Ballroom

General Assembly — **1 – 5:30 pm**
San Diego Ballroom

MSS Service Project and Presentation — **1 – 5 pm**
Leucadia Room

Educational Program: Professionalism on Social Media, and It's Uses in Networking, Advocacy, and Professional Development — **1 – 1:45 pm**
La Costa Room

Educational Program: I am Human: A Look at Shortcomings in the United States Prison Health Care System — **1:30 – 2:15 pm**
Coronado Room

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Research Expo **2 – 6 pm**
Grand Hall C-D (Manchester Grand Hyatt)

Symposium: Seeking Mental Health Care as Physicians and Future Physicians **2 – 3 pm**
Marina D

Educational Program: Structural Violence - Understanding the Bias Against Patients with a History of Substance Abuse **2:30 – 3:15**
Coronado Room

Educational Program: Cultural Humility and Implicit Bias: Moving Toward Equitable Health Care **3 – 3:45 pm**
La Costa Room

Educational Program: Unraveling the Mysteries of Surprise Billing **3:30 – 4:15**
Coronado Room

Educational Program: Health Care Think Tank – Members Moving Medicine **4 – 5 pm**
La Costa Room

Topics:
- Evidenced-Based Practices to Improve Maternal Mortality,
  Presenters: Neha Siddiqui and Reilly Bealler
- Protecting Immigrant Health and Well-Being,
  Presenter: Natasha McGlaun
- Trauma Informed Care,
  Presenter: Samantha Lund
- Encouraging Brain Donations to Brain Banks
  Presenters: Raj Reddy and Christopher Wong

Region Meetings **5:30 – 8 pm**

Region 1	Cardiff
Region 2	Del Mar
Region 3	Carlsbad
Region 4	Miramar
Region 5	Mission Hills
Region 6	Palomar
Region 7	Balboa

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New RD/AD Orientation **8 – 8:30 pm**
San Diego Ballroom

Saturday, November 16, 2019

ALL MSS Events on Saturday will be held at the Marriott Marquis

Delegate Credentialing **7 – 8 am**
San Diego Ballroom

General Assembly **8 am - Noon**
San Diego Ballroom

Educational Program: US Health Care Reform – Diving Into The Economic, Physician, and Patient Aspects of Proposed Health Care Plans **8 – 8:45 am**
La Costa Room

Educational Program: Developing Sustainable Global Health Projects in the Age of Voluntourism **8:30 – 9:15 am**
Coronado Room

Educational Program: Identifying Clinical Problems and Driving Needs-Oriented Innovation in Medicine **9 – 9:45 am**
La Costa Room

Educational Program: Using Cost-Effectiveness to Determine Coverage Priorities **9:30 – 10:15 am**
Coronado Room

Educational Program: Telemedicine and Mobile Apps – Accessing Birth Control Without Stepping Foot in a Clinic **10 – 10:45 am**
La Costa

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Professional.

Ethical.

Welcoming.

Safe.

This is what we expect of our members and guests at AMA-sponsored events.

All attendees are expected to exhibit respectful, professional and collegial behavior consistent with the Code of Conduct passed by the AMA House of Delegates.

We take claims of harassment and conflicts of interest seriously. Visit **ama-assn.org/codeofconduct** to learn more. Violations of the Code of Conduct may be reported as follows:

- Conduct liaison assigned to the meeting
- AMA Office of General Counsel
- AMA speaker or vice speaker
- Our third-party hotline at (800) 398-1496 or online at lighthouse-services.com/ama (which includes an anonymous reporting option)

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Meeting Logistics

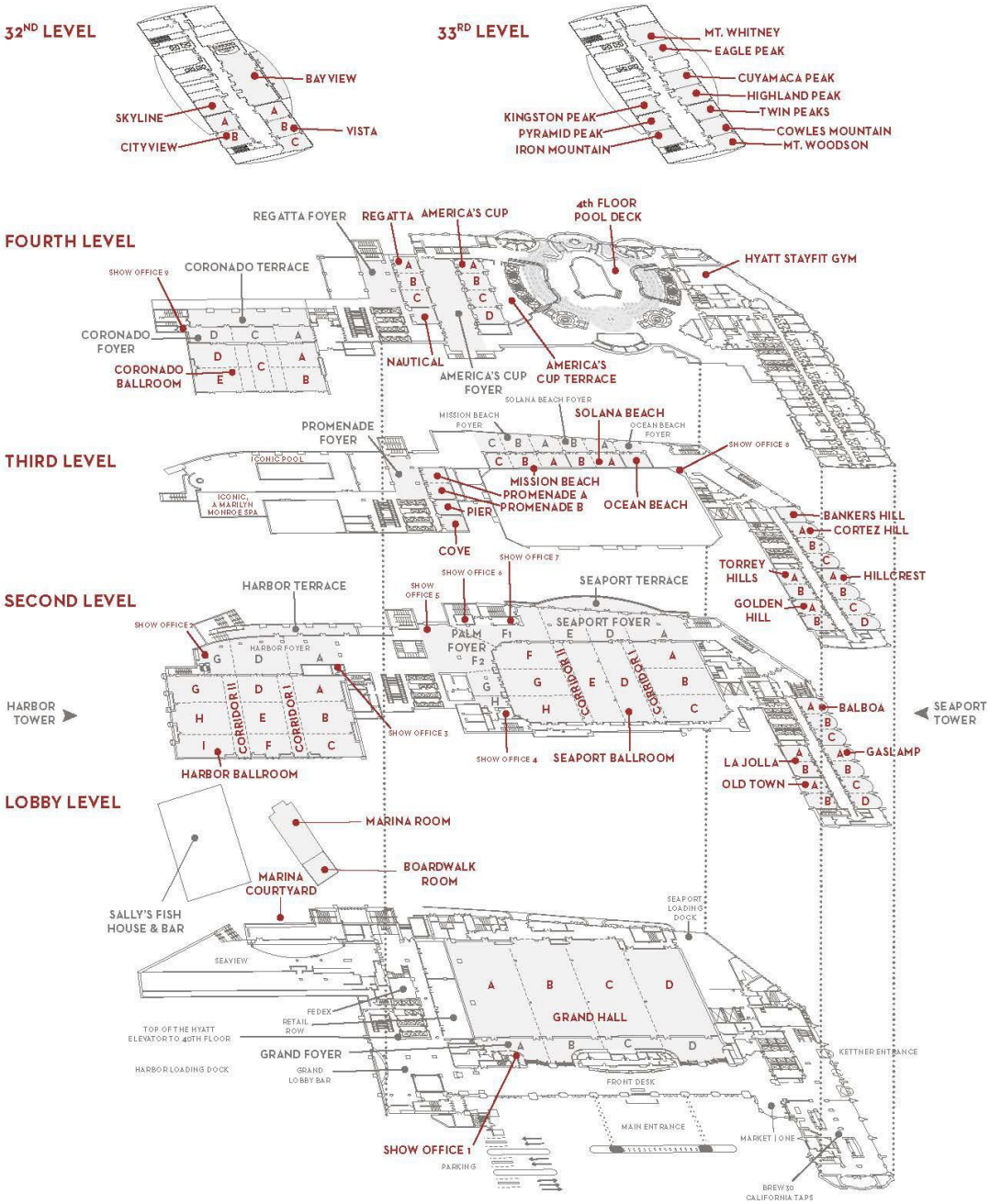
Wi-Fi: INTERIM2019 Password: INTERIM2019
Manchester Grand Hyatt hotel map Marriott Marquis hotel map
Meeting app information

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Manchester Grand Hyatt

FLOOR PLAN

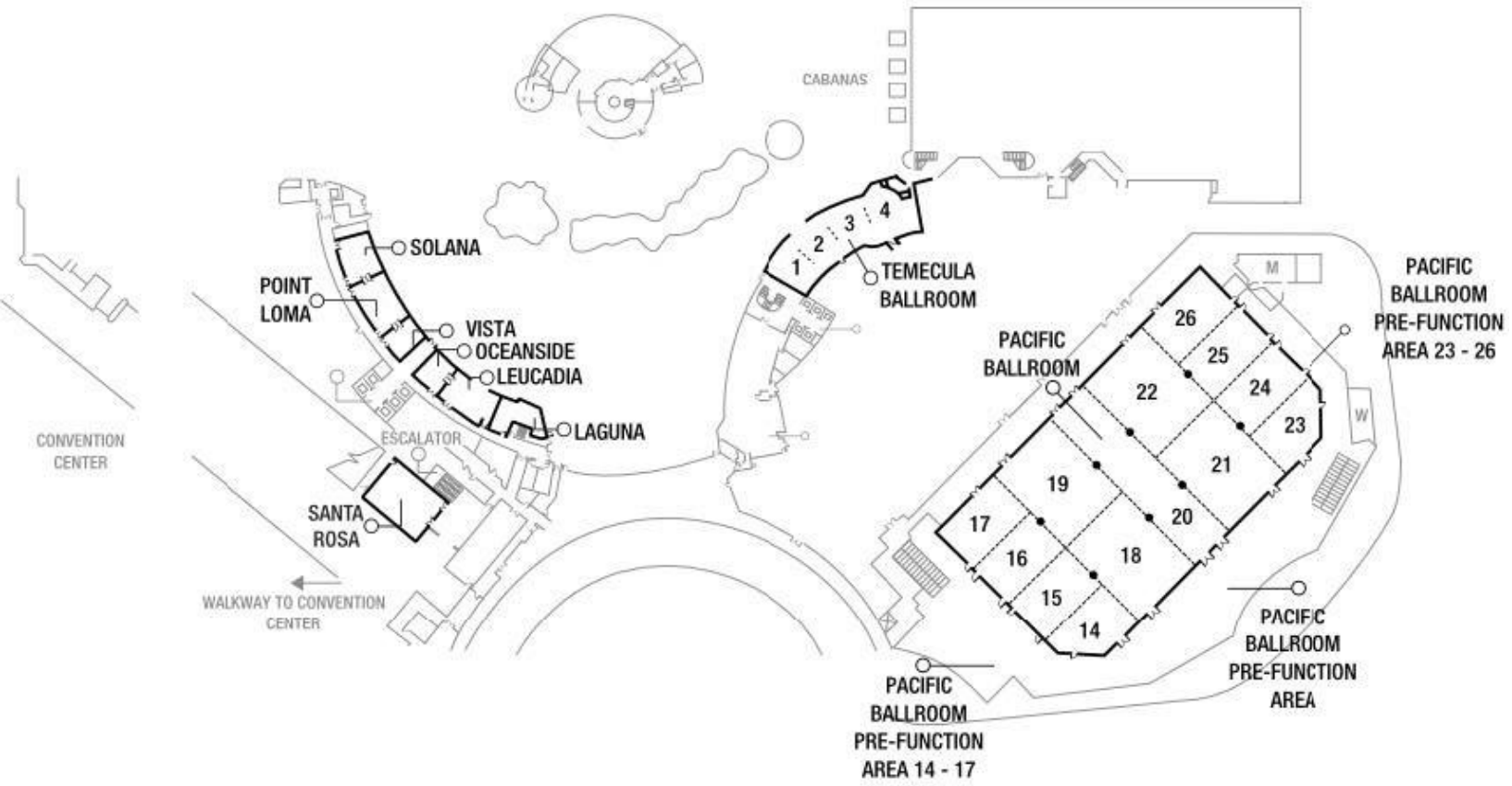
All Floors



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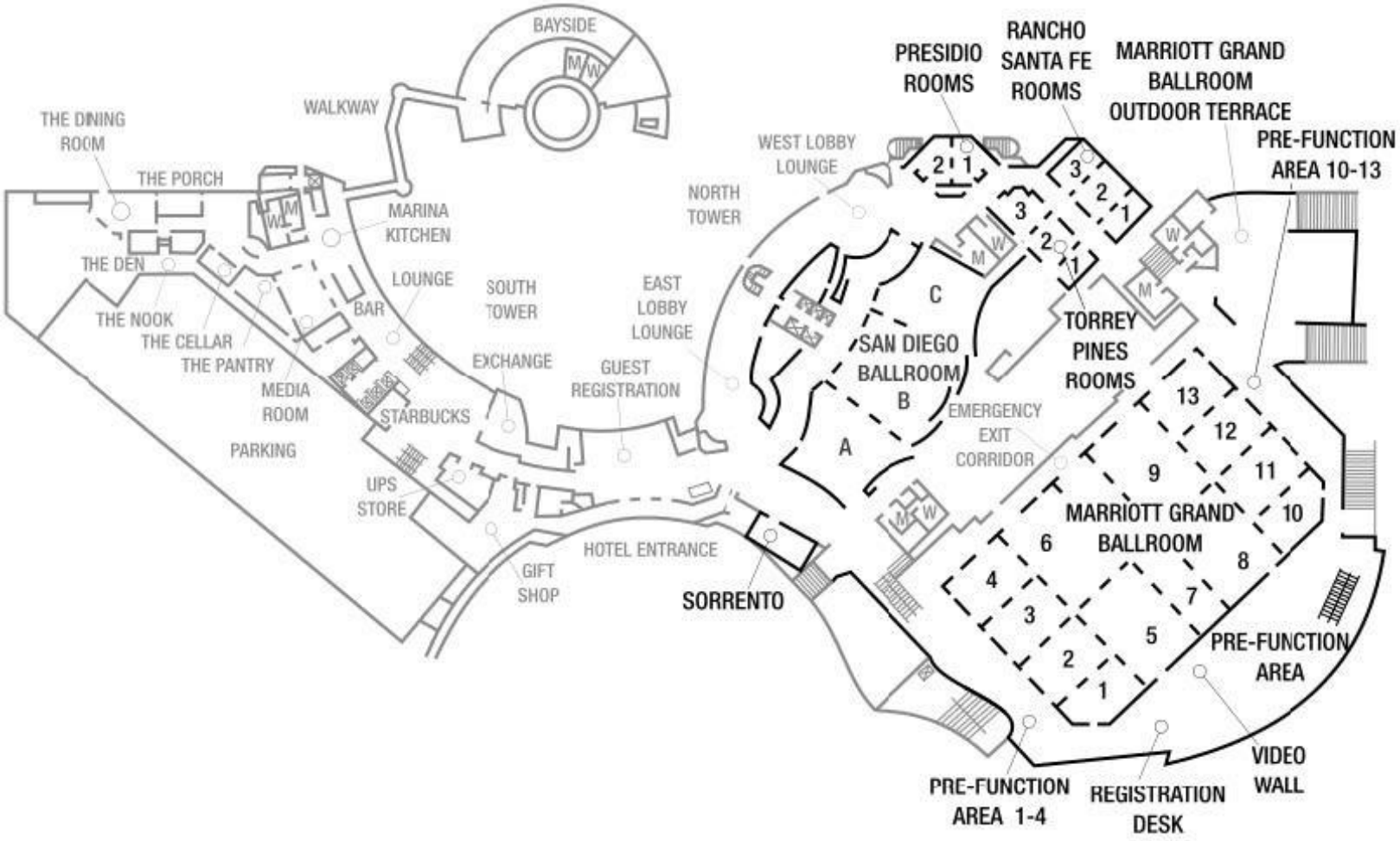
Marriott Marquis
Level One



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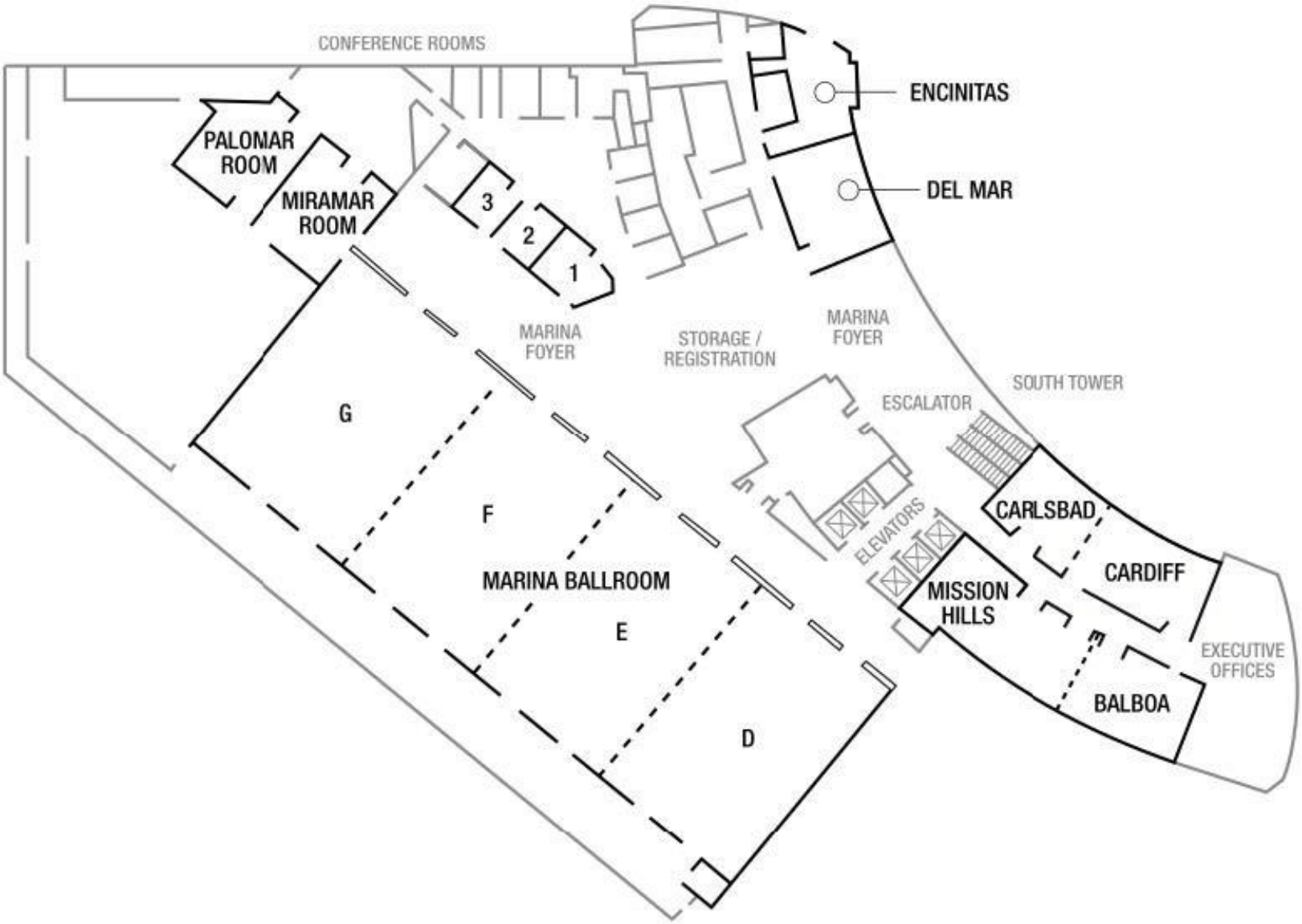
Marriott Marquis
Lobby Level



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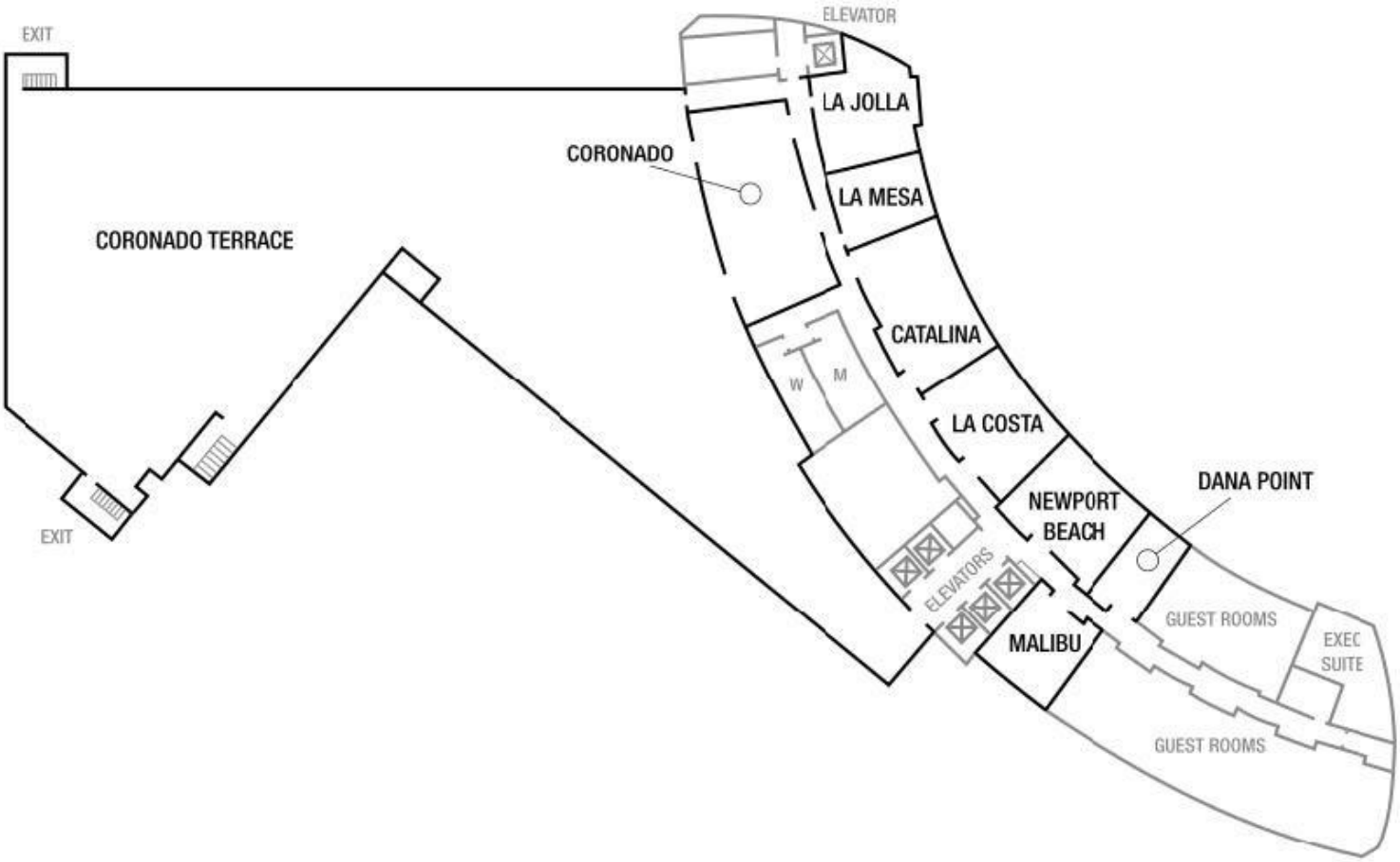
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Marriott Marquis
South Tower - Level 3



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Marriott Marquis
South Tower - Level 4



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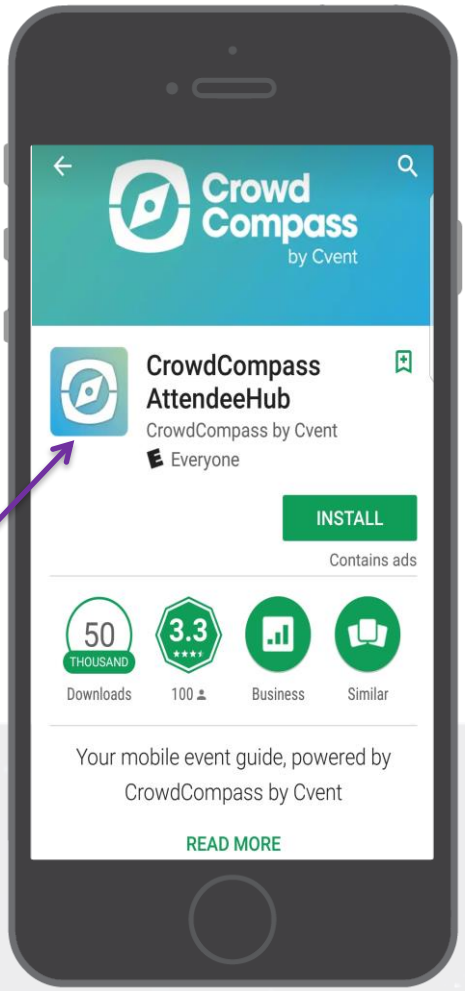
Downloading the App

Get the app

1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

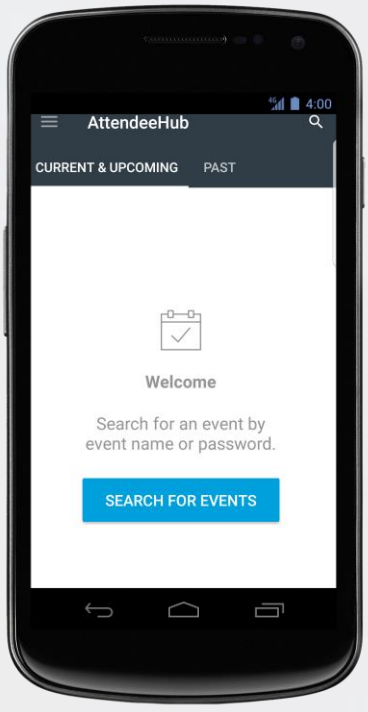
If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here:**
https://event.crowdcompass.com/amainterim19

or Scan here for online version



2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.



Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter
AMA 2019 Interim Meeting
2. Open your event. Tap the name of your event to open it.

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The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompassAttendeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.



AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/amaannual2019

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2019 Annual Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

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Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

Policy Materials

Section resolutions

- Resolution 01 – Amendment to Truth and Transparency in Pregnancy Counseling Centers
- Resolution 02 – Medical Licenses for Individuals with DACA Status
- Resolution 03 – Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV
- Resolution 04 – Co-payments in Prisons
- Resolution 05 – Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality among Children
- Resolution 06 – Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug-Related Felonies
- Resolution 07 – Amending H-350.957, Addressing Immigrant Health Disparities and D-440.927, Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services to Include Opposition to Legislation that Forces Decisions between Health Care and Lawful Residency Status
- Resolution 08 – Expanding AMA Support for Advanced Practice Providers who Provide First-Trimester Abortion Care

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Resolution 09 – Recognizing Loneliness as a Public Health Issue
Resolution 10 – Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs
Resolution 11 – Standard Procedure for Accommodations in USMLE and NBME Exams
Resolution 12 – Promoting Early Access to Diabetes Care to Reduce the Incidence of End-Stage Renal Disease
Resolution 13 – Expanding Insurance Coverage to Accommodate Bariatric Surgery in Qualified Individuals
Resolution 14 – Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections
Resolution 15 – Studying an Application Cap for the National Residency Match Program
Resolution 16 – Revising the Social Support Criterion of Organ Transplant Waitlist Eligibility
Resolution 17 – Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
Resolution 18 – Empowering Patients and Upholding Compliance with Healthcare Price Transparency via Actionable Enforcement Tools, and Amending D-155.987, Price Transparency
Resolution 19 – Expansion of Epinephrine Entity Stocking Legislation
Resolution 20 – Advancing the Role of Outdoor Recreation in Public Health
Resolution 21 – Using X-Ray and Dental Records for Assessing Immigrant Age

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Resolution 22 – Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
Resolution 23 – Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid
Resolution 24 – Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program
Resolution 25 – Advocating for the Amendment of Chronic Nuisance Ordinances
Resolution 26 – Urban Forestry as Public Health Infrastructure
Resolution 27 – Ethical Considerations of Big Health Data Research
Resolution 28 – Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
Resolution 29 – Support for Mental Health Courts
Resolution 30 – Racism as a Public Health Threat
Resolution 31 – Conforming Sex and Gender Designation on Government IDs and Other Documents
Resolution 32 – Amending H-160.963, to Include Supporting Increased Access and Reimbursement for Community-Based Recovery Services
Resolution 33 – Supporting the InCUS Report Recommendations to Explore Further Research into Possible Changes to the USMLE Step 1 Scoring System
Resolution 34 – Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

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Resolution 35 – Evaluating the Use of Third-Party Resources in Medical Education
Resolution 36 – Enhancing Transparency and Regulation in the Personal Care Product Industry
Resolution 37 – Support for Mental Health Absences for Students and Residents
Resolution 38 – Report and Recommendations on the Residency Application Process
Resolution 39 – Protecting Medical Student Access to Abortion Education and Training
Resolution 40 – Support for the Development of Guidelines Preventing Discrimination for People Seeking Preventive Medications
Resolution 41 – Increasing Access to Menstrual Hygiene Products in School Settings
Resolution 42 – Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
Resolution 43 – Ethics and Security of Brain-Computer Interfaces
Resolution 44 – Classification and Surveillance of Maternal Mortality
Resolution 45 – Enfranchisement of Incarcerated Persons
Resolution 46 – Gun Violence and Mental Illness Stigma in the Media
Resolution 47 – Advocating for Arbitration to Solve Surprise Medical Billing Practices
Resolution 48 – Support for Standardized Interpreter Training for Medical Students

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Resolution 49 – Support for Warning Labels on Firearm Ammunition Packaging
Resolution 50 – Naloxone Training in Correctional Facilities Prior to Release of People who are Incarcerated
Resolution 51 – Family Planning for Medical Students
*Resolution 52 – Evidence-Based Practices to Improve Maternal Mortality**
Resolution 53 – Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of the ACGME Single System of Accreditation
Resolution 54 – Buprenorphine Training in Medical Schools
*Resolution 55 – Protecting Immigrant Health and Well-Being**
Resolution 56 – Support for Assisted Outpatient Treatment
Resolution 57 – Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing
Resolution 58 – Supporting Collection of Data on Medical Repatriation
Resolution 59 – Incorporating the Choosing Wisely Program into Undergraduate and Graduate Medical Education
Resolution 60 – Increases in Government Funding of Programs that Teach Social Education and Housing Maintenance Skills for those with Mental Health Problems as a Means to Assist Eradicating Homelessness and Improve Outcomes
Resolution 61 – AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations
Resolution 62 – Mitigating the Effects of the Opioid Epidemic on the Foster Care System

**** This resolution has been withdrawn to participate in the Think Tank session***

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Resolution 63 – Addressing the Need for Firearm Safety in Medical School Curricula
Resolution 64 – Amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education
Resolution 65 – Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions
Resolution 66 – Hepatitis A Screening for At-Risk Populations
Resolution 67 – Oppose Tracking of People who Purchase Naloxone
Resolution 68 – Restricting the Use of Force by Law Enforcement Officers for Improved Public Health Outcomes
Resolution 69 – Supporting the Inclusion of Integrated Practice Units in Medical Care
Resolution 70 – Opposition of Corporal Punishment as a Form of Discipline
Resolution 71 – Support for Siblings of Chronically Ill Children
Resolution 72 – Restrictions on the Unlicensed Sale of Guns at Gun Conventions
Resolution 73 – Opposing Efforts that would Prevent Transgender or Questioning Youth from being Prescribed Puberty-Suppressing Medications by Physicians
Resolution 74 – Support for the Creation of a “Verified Badge” for Vaccine-Related Information Websites

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Resolution 75 – Utilization of Telesurgery in Rural America
Resolution 76 – Supporting External Accountability for ICE and CBP
Resolution 77 – Encouraging Brain and Other Tissue Donation for Research and Educational Purposes
Resolution 78 – Supporting the Use of Telemedicine to Screen and Diagnose Autism Spectrum Disorder
Resolution 79 – Early Sport Specialization in Youth Athletes
Resolution 80 – Peripartum Mental Health Coverage Under Children's Insurance
Resolution 81 – Supporting Social Comparison Feedback Initiatives to Improve Physician Stewardship
Resolution 82 – Metformin Education for Diabetes Mellitus Type 2 Patients with Chronic Kidney Disease
Resolution 83 – Student-Centered Approaches for Reforming School Disciplinary Procedures
Resolution 84 – Increased Recognition and Treatment of Eating Disorders in Minority Populations
Resolution 85 – Medicaid and Medicare Alone without Supplemental Coverage of Outpatient Chemotherapy Ambulatory Pump for Patients with Colorectal and Esophageal Cancer
Resolution 86 – Amending H-95.922, Substance Use and Substance use Disorders, to Include Standardization of Human Trafficking Data and Medical
Resolution 87 – Standardization of Human Trafficking Data and Medical Training
Resolution 88 – Support Bleeding Control Training for Students in Grades K-12

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Resolution 89 – IOP Change to Clarify MSS Conflict Resolution Process

Section reports

CEQM MIC Report A – Laying the First Steps Towards a Transition to a Financial and Citizenship Need-Blind Model for Organ Procurement and Transplantation
CGPH CBH Report A – A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder
CGPH Report A – Improving the Health and Safety of Consensual Sex Workers
CHIT CBH Report A – Implementing a Standardized Patient Flag System in the Electronic Medical Record
CME Report A – Requiring Blinded Review of Medical Student Performance
CME Report B – Improving Support and Access for Medical Students with Disabilities
LGBTQ+ MIC Report A – Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
GC Report A – Policy Sunset Report for AMA-MSS Policies

MSS Reference Committee Report

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 01
(I-19)

Introduced by: Region 1; Region 2; Region 3; Region 4; Carly Polcyn, University of Toledo College of Medicine; Shira Yellin, Albert Einstein College of Medicine

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC) or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to dissuade women from seeking legal abortion to terminate pregnancy[1]; and

Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive medical facilities with licensed clinical professionals despite offering only select services, providing misinformation regarding abortion and contraception, and being largely staffed by volunteers instead of licensed care providers[2,3]; and

Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable populations like minority and low-income women, which are the target population pursued by Pregnancy Counseling Centers[4]; and

Whereas, Our AMA submitted an amicus brief to The U.S. Supreme Court on the grounds of ”medical ethics and a patient’s right to informed consent” opposing the Supreme Court’s decision in regards to the case titled *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, which ultimately did not uphold California’s 2016 Reproductive Freedom, Accountability, Comprehensive Care and Transparency (FACT) Act to require all licensed medical facilities to publicly post information about affordable abortion and contraception services offered by the state on their premises and all unlicensed CPCs to disclose that they were not licensed medical clinics arguing on the grounds of, “medical ethics and a patient’s right to informed consent”[5-7]; and

Whereas, The public health repercussions that these entities pose by influencing women’s reproductive health decisions is well established by putting women at greater risk when they are interrupted from seeking abortions in a timely manner, therefore subjecting them to the increased risk associated with late term abortions or unsafe abortions, and also perpetuating decreased prenatal care, substance abuse, preterm births, and increased incidence of negative physical and mental outcomes of babies that are born to women with unintended pregnancies[8]; and

Whereas, Our AMA recognizes the unethical and dubious practices utilized by Pregnancy Counseling Centers in the Journal of Medical Ethics such as providing misleading and false

information that falls outside of medical standards, can cause women to miss abortion law cutoffs or receive more dangerous late-stage abortions, and obstructs access to abortion, which violates the ethical standards of beneficence, respect for autonomy, nonmaleficence, and justice, respectively[9], and

Whereas, Pregnancy Counseling Centers, although publicly posing as non-profit organizations, can use federal funds from programs like Temporary Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title X family planning funding programs to fund their clinic's services despite only offering a limited, and often incomplete, number of services[10, 11]; and

Whereas, Pregnancy Counseling Centers can be funded by religious, anti-choice organizations despite not disclosing this connection, such as profits made by "Choose Life" license plates which fund Pregnancy Counseling Centers in 32 states[12]; and

Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as of 2015, $60 million in federal abstinence and marriage promotion funds have gone to Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to Pregnancy Counseling Center [13, 14]; and

Whereas, In states such as Alabama, Georgia, Idaho, Kansas, Louisiana, Minnesota, North Carolina, Oklahoma, South Carolina, Texas, West Virginia, and Alaska with "Woman's Right to Know" laws, which delay a women's ability to obtain an abortion by requiring counseling, an ultrasound image or listening to fetal heart tones, and a mandatory waiting period before obtaining an abortion, referrals to Pregnancy Resource Center websites are made through state resource directories or state health departments[15]; and

Whereas, A survey conducted of 254 Web sites that identified individual Pregnancy Counseling Centers revealed only 85 out of 254 contained information on male condoms or sexually transmitted infections (STIs), and of these 63.5% discouraged condom use by providing negative facts about condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or videos of youth on their homepage to target younger populations[15]; and

Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on search engine results, billboards, and buses near abortion clinics with abortion-related terms while hiding their agenda to dissuade women from seeking legal abortions[16]; and

Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful tactics to dissuade women from seeking legal abortion such as wearing white coats although they hold no medical training, failing to disclose they are not a medical facility, expressing judgement to clients about their decisions to pursue abortion or contraception, offering ultrasound services for purpose of using fetal images to dissuade women from abortion, and providing false information on the links between abortion and adverse mental health sequelae, breast cancer, and future infertility[16,17]; and

Whereas, Because Pregnancy Counseling Centers do not charge for services and are often not licensed medical practices, they are not held to the same state consumer protection statutes and Consumer Protection regulations which medical practices must abide by[9]; therefore be it

RESOLVED, That our AMA amend policy H-420.954, Truth and Transparency in Pregnancy Counseling Centers by insertion and deletion as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by Pregnancy Counseling Centers:

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have; and be it further

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy; and be it further;

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services; and be it further

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954
1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further

2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 02
(I-19)

Introduced by: Region 3; Region 7; Tristan Mackey, Haritha Pavuluri, and Rachel Michelle Shugart, University of South Carolina School of Medicine Greenville

Subject: Medical Licenses for Individuals with DACA Status

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Deferred Action for Childhood Arrivals [DACA] program allows individuals who arrived in the United States before the age of 16 to obtain temporary lawful status without the fear of deportation[1]; and

Whereas, Those with DACA status are considered to be lawfully present and may apply for work authorization[1]; and

Whereas, The total number of individuals with DACA status as of April 2019 is 669,080 people[2]; and

Whereas, Since being enrolled or having completed high school or a GED program is a requirement to be considered for DACA status, these students receive the same education within the public education system as those who are citizens of the United States[3]; and

Whereas, Many of these students pursue higher education in order to obtain a medical doctorate degree, despite being ineligible to receive in-state tuition or federal student aid[3,4]; and

Whereas, Individuals with DACA status who become physicians could both serve to lessen the predicted physician shortage, and also provide a culturally diverse and bilingual physician workforce[3,5,6]; and

Whereas, All but 10 states still do not have laws that will allow individuals with DACA status to obtain a professional license, including a medical license[3,4,7,8]; and

Whereas, The ultimate decision to grant a medical license is determined on a state to state basis, and based on regulations within each state[3,4,8]; and

Whereas, The changes that have been made in the laws of those 10 states, including California, Florida, West Virginia, and New York, that allow for individuals with DACA status to obtain professional medical licenses have happened within the last 4 years[7,8]; and

Whereas, Our AMA supports studying opportunities for DACA-eligible medical students, residents, and physicians can participate in the physician profession (AMA Policy D-350.986); therefore be it

RESOLVED, That our AMA supports the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses from state medical licensing boards; and be it further

RESOLVED, That our AMA encourages state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

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;
(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 States 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;
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited **license**;
(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of re-licensure or re-registration; and
(24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.

Graduates of Foreign Health Professional Schools H-255.985
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.

Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages 295.185MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 03
(I-19)

Introduced by: Region 3; Region 4; Region 5; GLMA: Health Professionals Advancing LGBTQ Equality; Student National Medical Association

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior[1]; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual[2]; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately[2]; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic[3]; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM[4]; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women[5-6]; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention[5-6]; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population[3]; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos[7]; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily[8-9]; and

Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million additional individuals would benefit from being on it[10-13]; and

Whereas, 69% of these individuals that could benefit from PrEP are Black or Hispanic, yet these individuals comprise only 4% of the individuals that are prescribed it[11-12]; and

Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the USA, with people of color and women bearing a high HIV burden, but having a disproportionately limited uptake[14]; and

Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the most frequently cited barrier to prescribing it being lack of knowledge[15-16]; and

Whereas, A 2018 study showed that medical students were unable to identify individuals at highest risk of HIV acquisition and recommend PrEP accordingly[17]; and

Whereas, Educational interventions targeted at primary care physicians that focus on HIV epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to increase rates of PrEP prescribing when clinically indicated[16]; and

Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality, contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as early as age 11[18-19]; and

Whereas, It is considered a best practice in primary care settings to educate patients about all the available options for preventing STIs, especially in sexually active adolescents and in adults at increased risk for STIs[18-19]; and

Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients[8,15]; and

Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP uptake, was suggestion to initiate PrEP by a healthcare provider[14]; and

Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective medical diagnosis and treatment"; and

Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the consistency and equity of care for all persons" and "supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations"; and

Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV prevention and treatment nor proposes a specific intervention to reduce such disparities; therefore be it

RESOLVED, That our AMA amend AMA Policy H-20.895 "Pre-Exposure Prophylaxis (PrEP) for HIV" by insertion to read as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

1. Our AMA will educate physicians, physicians-in-training, 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.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

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

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

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.

Modified: Res. 16, A-18.

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:

1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974

1. 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.
2. The AMA emphasizes three approaches that it believes should be given high priority:
    a. 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.
    b. 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.
    c. 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

3. 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.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Reaffirmed: CMS Rep. 10, A-19

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.

Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the

effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.
(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS
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.
Reaffirmed: MSS GC Rep D, I-15.

Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers 65.017MSS
AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations.
Reaffirmed: MSS GC Rep A, I-16.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 04
(I-19)

Introduced by: Region 1

Subject: Co-payments in Prisons

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Federal Bureau of Prisons and prisons in at least 35 states require a copayment (copay) to access healthcare; the average copay across the 50 states is $3.47 and, in Texas, each prisoner must pay a $100 fee for healthcare each year[1,2]; and

Whereas, Prisoners are prohibited from accessing Medicaid, unless they are being treated outside the institution, such as a hospital or nursing home, for 24 hours or more, limiting prisoners' access to healthcare while in prison[3]; and

Whereas, Inmates and their families are charged a variety of fees to help offset correctional costs, which can include charges for room, meals, booking into prison, clothing, toilet paper, phone calls to family, personal hygiene products, emergency medical care, hospitalization, as well as primary healthcare[1,4,5,6,7]; and

Whereas, An analysis by Pew Charitable Trusts found that states collectively spent approximately 7.7 billion dollars for inmate healthcare for inmates in 2011, and states reported that they only recouped between $190,000 and $500,000 a year from prisoner copays, indicating copays are not an effective means of offsetting correctional costs[8]; and

Whereas, In at least seven states, prisoners do not receive a salary for working, and in states where they do, they receive between 4 and 40 cents an hour, with the average minimum wage job in prison totaling 14 cents an hour, requiring an average of 25 hours of work to afford to see a doctor [2,9]; and

Whereas, Prisoners have an increased rate of infectious disease, stress-related illness, obesity, and an increased risk of mortality in prison[10,11,12]; and

Whereas, A study, published in the Journal of Correctional Care, found that in Texas, prisoners' age- and race-adjusted average annual death rates due to infection were two to three times higher than the annual infection death rates among non-incarcerated males in Texas[13]; and

Whereas, Infectious disease transmission rates are much higher in prison[14]; and

Whereas, A systematic review found that more widespread screening and treatment of the infectious diseases Human Immunodeficiency Virus (HIV), Hepatitis C, and Tuberculosis in prisons could reduce the rate of transmission, both in prison and in the wider community[14]; and

Whereas, Copayments that are difficult to afford can prevent prisoners from seeking necessary treatment to their own detriment, and with communicable diseases, to the detriment of the wider prison population and increase the cost of providing care in prison[8]; and

Whereas, Current AMA policy H-65.963 calls for advocacy on behalf of vulnerable populations, such as prisoners and other classes of vulnerable populations, including ethnic and racial minorities, as well as those with mental health illnesses who are disproportionately represented in correctional, detention, and juvenile facilities[15,16]; and

Whereas, Current AMA policy D-430.977 highlights the AMA's commitment to improving healthcare services in correctional, detention, and juvenile facilities; therefore be it

RESOLVED, That our AMA advocate for the prohibition of the use of copayments to access healthcare services in correctional facilities.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. Res. 001, A-18

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will: (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities; (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and (6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion. Appended: Res. 426, A-19

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to

comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. Appended: Res. 420, A-19

Patient Access to Anti-Tuberculosis Medications H-440.840
Our AMA supports state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease. Res. 120, A-13

Insurance Coverage for Immunizations H-185.969
Our AMA endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles. Reaffirmation A-11

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products, including tampons for their needs. Res. 218, A-18.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 05
(I-19)

Introduced by: Region 3; Region 7; Massachusetts Medical Society; Texas Medical Society

Subject: Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality among Children

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The World Health Organization (WHO) urges Member States "to identify the most suitable policy approach to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt"[1,2]; and

Whereas, The American Academy of Pediatrics and American Heart Association recommend changing federal tax law to prohibit food and beverage companies from deducting all or part of the cost of marketing unhealthy products[3]; and

Whereas, The Federal Tax Code allows advertising costs to be deducted as a regular business expense for tax purposes and avoid taxation at the corporate tax rate[4]; and

Whereas, Targeted advertising to children is defined as those advertisements that appear alongside television programs with an audience share of at least 30% for children aged 2–11 years or 20% for adolescents aged 12–17 years[5]; and

Whereas, Television advertising heavily informs children's food knowledge, preferences, purchase requests, and consumption patterns, and is associated with increased consumption of sugary snacks and beverages, as well as excess calorie intake, and a majority of food-related advertisements viewed by American youth feature primarily unhealthy categories of food [6-7]; and

Whereas, The Council of Better Business Bureaus launched the Children's Food and Beverage Advertising Initiative (CFBAI) in 2006 to create a coalition of food and beverage companies, including 17 of the nation's largest food companies, pledging to promote healthier foods and beverages, based first on company-defined and then uniform standards[8]; and

Whereas, There has been no significant improvement in the nutritional quality of foods marketed to children since the CFBAI's launch, indicating that industry self-regulation is insufficient[8]; and

Whereas, The Interagency Working Group (IWG) on Food Marketed to Children was established in 2009 to draft "voluntary nutrition principles to guide industry self-regulatory efforts to improve the nutritional profile of foods that are most heavily marketed to children" and is comprised of representatives from the Federal Trade Commission, the Centers for Disease

Control and Prevention, the Food and Drug Administration, and the United States Department of Agriculture[9]; and

Whereas, The IWG recommends that foods and beverages marketed to children should (Principle A) provide a meaningful contribution to a healthful diet and (Principle B) should not surpass certain limits for nutrients, including saturated fat, trans fat, added sugars, and sodium, not counting naturally occurring nutrients[9]; and

Whereas, Nearly all products featured in CFBAI company-member advertisements and 80-90% of non-CFBAI company advertisements seen on children's programming are high in IWG nutrients to limit, indicating that IWG guidelines are not being followed[4]; and

Whereas, Elimination of tax subsidies for advertisements that promote nutritionally poor foods and beverages among children is considered one of the most cost-effective interventions against childhood obesity by reducing the incentive for the food industry to advertise obesogenic foods and drinks to children[4,10,11]; and

Whereas, It is estimated that eliminating this tax subsidy would yield an aggregate decrease of 2.14 million BMI units in the population, resulting in a net gain of 4,528 quality-adjusted life years over a 10-year period[4]; therefore be it

RESOLVED, That our AMA advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by the Interagency Working Group's guiding principles; and be it further

RESOLVED, That our AMA urge food and beverage companies to adhere to the Interagency Working Group's recommended nutrition principles to improve the nutritional profile of foods that are marketed to children.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Television Commercials Aimed at Children H-485.998
Our AMA opposes TV advertising and programming aimed specifically at exploiting children, particularly those ads and programs that have an impact on the health and safety of children. Res. 27, A-79; Reaffirmation A-12

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third-party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
CSA Rep. 6, A-99; Reaffirmation: A-19

Obesity as a Major Health Concern H-440.902
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 patients with obesity; (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 patients affected by obesity.
Res. 423, A-98; Modified: Res. 402, A-17

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960
The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.
Res. 405, A-94; 13 Modified: CSAPH Rep. 03, A-17

Nutrition Education H-150.996
Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools.
Sub. Res. 66, I-77; Modified: CME Rep. 01, A-17

Quality of School Lunch Program H-150.962
1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
Sub. Res. 507, A-93; Appended: Res. 206, I-17

Regulating Front-Of-Package Labels on Food Products 150.035MSS
AMA-MSS asks that our AMA 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) AMA support the use of front-of-package warning labels on foods that contain excess added sugar
MSS Res 14, A-18

Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners 150.022MSS
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 06
(I-19)

Introduced by: Region 1; Region 2; Region 5

Subject: Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Under current federal law, any individual convicted of a drug-related felony is not eligible for benefits under the Supplemental Nutrition Assistance Program (SNAP)[1]; and

Whereas, As of March 2019, only 3 states and territories currently maintain this lifetime ban, 24 states have modified this ban on SNAP for persons convicted of a drug-related felony, and 25 states have repealed this ban altogether[2,3]; and

Whereas, This provision was originally a small part of a much larger welfare-reform package passed in 1996 to deter individuals from drug-related crimes and decrease misuse of the welfare system[4]; and

Whereas, Many state-based modifications to this ban entail limiting the classes of drug felonies subject to restriction, creating short-term bans, requiring drug-testing for enrollees, and requiring enrollment and participation in drug treatment programs[5]; and

Whereas, Based on a regression discontinuity analysis performed with data comparing recidivism in convicted drug traffickers in Florida immediately before and after the institution of the federal SNAP ban, banning access to SNAP has been associated with an increased likelihood of criminal recidivism[6]; and

Whereas, An economic study examining administrative data on released offenders in 43 states has found that eligibility for SNAP and Temporary Assistance for Needy Families (TANF) “at the time of release from prison significantly reduces the risk of returning to prison within one year by up to 10%”[7]; and

Whereas, Food insecurity is defined by the condition of households that, at times, were “unable to acquire adequate food for one or more household members because they had insufficient money and other resources for food”[8]; and

Whereas, 11.1% of American households reported experiencing food insecurity at least at some point during 2018[5], while a pilot study with a sample size of 110 former drug offenders indicated a food insecurity prevalence of 91%[9], and a study of 304 probationers (not limited to drug-related charges) in Rhode Island found a food insecurity prevalence of 70.4% compared to the overall state prevalence of 12.8%[10]; and

Whereas, Food insecurity is associated with higher risk of chronic disease, including diabetes, obesity, depression, and hypertension[11,12]; and

Whereas, Access to SNAP benefits has been associated with improved health as indicated subjectively by higher ratings of self-assessed health, with significantly increased probability of reporting excellent or very good health, and objectively by fewer days in bed due to illness[10]; and

Whereas, SNAP participants have been found overall to consume fewer office-based medical visits compared to counterparts who do not participate in SNAP, although they utilize medical services for general checkup visits at a greater rate than non-participants[13]; and

Whereas, Existing AMA policy (H-270.966) opposes requiring that applicants to SNAP disclose medical information, including former drug use and treatment history, and opposes denying assistance from these programs based on substance use status, and also supports the preservation of SNAP to increase access to healthful foods and decrease food insecurity (H-150.937); and

Whereas, Current AMA policy does not address the impact of current federal law regarding criminal drug offenses and subsequent access to SNAP benefits; therefore be it

RESOLVED, That our AMA opposes any lifetime ban on SNAP benefits imposed on individuals convicted of felonies.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966
Our AMA opposes: a) requiring that 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 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.

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 07
(I-19)

Introduced by: Tristan Mackey, Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Sathwika Thodeti, Northeast Ohio Medical University; Joey Whelihan, University of Florida; Joyce Wang, Harvard Medical School; Jin Lee, Northeast Ohio Medical University; Jerome Soldo, University of Louisville School of Medicine; Hannah Meissner, Creighton University School of Medicine; Devin John, University of Cincinnati College of Medicine; Divy Mehra, Nova Southeastern KP College of Osteopathic Medicine

Subject: Amending H-350.957, Addressing Immigrant Health Disparities and D-440.927, Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services to include opposition to legislation that forces decisions between health care and lawful residency status

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, A public charge has been defined as an immigrant who is applying for a lawful permanent resident card (“Green Card”) who is deemed to be, or likely to become, dependent on public benefits[1]; and

Whereas, In the original conception of the public charge rule by the Department of Homeland Security [DHS] in 1999, only use of public cash assistance or institutionalization in a government funded facility were to be considered as a public charge[1,2]; and

Whereas, The determination of being a current or future public charge results in grounds for inadmissibility, or inability to be granted legal permanent residency[2]; and

Whereas, In August 2019, the federal government announced a final rule to increase the non-cash public assistance programs in consideration for inadmissibility to now include non-emergent Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), the Children’s Health Insurance Program (CHIP), several housing programs, and their Federal poverty level determination[2]; and

Whereas, The original 1999 public charge determination had specifically prohibited the consideration of non-emergent Medicaid for non-pregnant adults, SNAP, CHIP, and these housing programs in determining Legal Permanent Residency application[2]; and

Whereas, DHS estimated that 382,600 green card applications and 517,500 applications for other types of visas would be subject to the new public charge criteria annually[3]; and

Whereas, Public charge determination discourages use of publicly funded healthcare and welfare services, which is known as the chilling effect, or the fear and confusion about the rule, even among immigrant families to which the rule does not technically apply [1,2]; and

Whereas, In a survey of 1,950 adults in immigrant families that was conducted in December 2018, one in seven or 13.7% reported either not applying for or dropping out of a non-cash benefit program for fear of risking future green card status[4]; and

Whereas, A total of 8.3 million children are at risk of losing Medicaid and CHIP and/or household nutrition assistance, of whom 5.5 million had specific medical needs[1]; and

Whereas, Approximately 10.5 million children in families receiving public assistance have at least one noncitizen parent[3]; and

Whereas, Those with children less than 19 years in the household (17.4%) were more likely to report avoiding public benefit programs[4]; and

Whereas, Decreased participation in these programs would contribute to a greater uninsured population, a decrease in the use of both preventive and curative health services, and negatively affect the health outcomes and financial stability of nearly 22 million noncitizens currently residing in the U.S.[2,5,6]; and

Whereas, Non-cash public benefits successfully contribute to increased prescription adherence and decreased rates of uncompensated medical care, communicable diseases, obesity, malnutrition, housing instability, and poverty, which beget higher educational attainment and productivity[3]; and

Whereas, The final public charge rule sets a precedent for future immigration policy to discriminate based on poverty level, housing status, and the need for public benefits[6]; and

Whereas, The information published in the Federal Register within the final rule states that Department of Justice [DOJ] regulations concerning deportation and inadmissibility on public charge grounds are in the process of being developed[7,8]; and

Whereas, the 3rd AMA Principle of Medical Ethics states, “A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient”[9]; and

Whereas, Our AMA is opposed to any proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP (AMA Policy D-440.927); therefore be it

RESOLVED, That our AMA amend H-350.957, Addressing Immigrant Health Disparities by insertion as follows:

Addressing Immigrant <u>and Refugee</u> Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of <u>immigrants and</u> refugees and encourages the exploration of issues related to <u>immigrant and</u> refugee health and support legislation and policies that address the unique health needs of <u>immigrants and</u> refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status.

5. Our AMA opposes the use of age, disability, previous medical conditions, housing status, or federal poverty level in the determination of a refugee or immigrant's ability to become a lawful permanent resident.

; and be it further

RESOLVED, That our AMA amend D-440.927, Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services, by insertion as follows:

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

1. Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

2. Our AMA is opposed to deportation based on the use of non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, the need for public housing assistance, and federal poverty level.

Fiscal Note: TBD

Date Received: 09/20/2019

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2. Changes to "Public Charge" Inadmissibility Rule: Implications for Health and Health Coverage. The Henry J. Kaiser Family Foundation. 2019 Aug.
3. The "Public Charge" Proposal and Public Health Implications for Patients and Clinicians. JAMA Network. 2018.
4. With Public Charge Rule Looming, One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. 2019.

5. Joint Statement of America's Frontline Physicians Opposing Public Charge Final Rule. American College of Obstetricians and Gynecologists. 2019 Aug.
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7. Inadmissibility on Public Charge Grounds. Federal Register. 2018 Aug.
8. Featured Issue: Public Charge Changes at USCIS, DOJ, and DOS. American Immigration Lawyers Association. 2019 Aug.
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RELEVANT AMA AND AMA-MSS POLICY

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) 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; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS
(1) That our AMA 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 (2) That our AMA 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 08
(I-19)

Introduced by: Region 1; Region 2; Eshani Dixit, Robert Wood Johnson Medical School; Rajadhar Reddy, Baylor College of Medicine.

Subject: Expanding AMA Support for Advanced Practice Providers Who Provide First-Trimester Abortion Care

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Access to safe, quality abortion care in the United States is limited, with six states currently having only one abortion clinic (Arkansas, Kentucky, Louisiana, Mississippi, Missouri, and Ohio) and another two states in danger of also being reduced to one clinic[1]; and

Whereas, Historical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers[2]; and

Whereas, Abortion providers are concentrated in large cities, and nonmetropolitan areas (which comprise 97% of all US counties) lack an abortion provider, indicating a shortage of access to abortion for rural populations[3,4]; and

Whereas, Advanced practice providers (nurse practitioners, physician assistants, certified nurse midwives) are more likely than physicians to provide primary care in rural community settings that serve Medicaid enrollees and vulnerable populations, suggesting an opportunity to expand services to make abortion care more accessible, particularly in rural communities[5]; and

Whereas, In the United States, 88% of abortions occur within the first trimester, when abortion is safest[6]; and

Whereas, Aspiration abortions account for over 70% and medication abortions comprise 26% of all first trimester abortions[6]; and

Whereas, The skills needed to provide first trimester medication and aspiration abortions, including assessing gestational age, counseling, providing medications, performing supervised medication or vacuum aspiration abortions, and conducting follow-up care are in the scope of practice of primary care clinicians and advanced practice providers[5]; and

Whereas, The National Academies of Sciences, Engineering, and Medicine (NASEM) stated in a 2018 consensus study that advanced practice providers, including physician assistants, certified nurse-midwives, and nurse practitioners, can safely and effectively provide first-trimester medication and aspiration abortions[7]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) published a 2014 statement, reaffirmed in 2019, recommending "expanding the pool of first-trimester medication and aspiration abortion providers to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements"[8]; and

Whereas, The American Public Health Association (APHA) published a 2011 statement, updated in 2014, recommending "the provision of medication and aspiration abortion by appropriately trained and competent NPs, CNMs, and PAs," "that all health professionals educate themselves, their colleagues, and the public about the value of NPs, CNMs, and PAs and their capacity to increase access to safe abortions," and "address[ing] barriers to NPs, CNMs, and PAs as qualified primary care clinicians and safe providers of abortion services"[9]; and

Whereas, The WHO safe abortion guidance recommends that abortion services be "provided at the lowest appropriate level of the health care system", with mid-level health workers, including "midwives, nurse practitioners, physician assistants" trained to provide medication and vacuum aspiration abortions to increase the number of health service sites offering first trimester abortions and improve women's access to abortion services without compromising safety or quality of care[10,11]; and

Whereas, Several studies have long established that clinical outcomes in first-trimester medication and aspiration abortions are not significantly different between physicians or advanced practice providers [12-17]; and

Whereas, Currently only five states allow advanced practice providers to provide first-trimester medication and aspiration abortions[18]; and

Whereas, AMA Policy H-5.995 states that "abortion...should be performed only by a duly licensed physician and surgeon," and AMA Policy H-5.983 states that "pregnancy termination be performed only by appropriately trained physicians (MD or DO)," both of which are explicitly in conflict with ACOG's opinion, APHA's policy, WHO recommendations, and the evidence provided by NASEM; therefore be it

RESOLVED, That our AMA amend H-5.995 by addition as follows:

Abortion H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician, ~~and~~ surgeon, or advance practice provider in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment.
; and be it further

RESOLVED, That our AMA amend H-5.983 by addition as follows:

Pregnancy Termination H-5.983
The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO) and advanced practice providers.
; and be it further

RESOLVED, That our AMA support state and federal legislation that allows appropriately trained and credentialed advanced practice clinicians to perform first trimester medical and aspiration abortions in accordance with individual state licensing requirements.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Late-Term Pregnancy Termination Techniques H-5.982
1. The term 'partial birth abortion' is not a medical term. The AMA will use the term "intact dilation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

2. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

3. The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

4. In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which

demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.
BOT Rep. 26, A-97 Modified and Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: CSAPH Rep. 01, A-17

MSS Stance on Challenges to Women's Right to Reproductive Health Care Access 5.005MSS
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, I11) (Reaffirmed: MSS Res 27, A-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 09
(I-19)

Introduced by: Region 2; Region 4; Swathi Murthy, Northeast Ohio Medical University

Subject: Recognizing Loneliness as a Public Health Issue

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Loneliness is defined as "the discrepancy between a person's preferred and actual level of social contact," and social isolation is defined as "an objective state of having minimal social contact with other individuals"[1]; and

Whereas, The World Health Organization lists "social support networks" as a determinant of health[2]; and

Whereas, The 2018 Cigna US Loneliness Index found that nearly half of US adults report sometimes or always feeling lonely[3]; and

Whereas, Younger generations experience more loneliness than older generations[3]; and

Whereas, Loneliness in adolescence is associated with impaired sleep, symptoms of depression, and poorer health in general[4]; and

Whereas, Loneliness is a significant predictor of functional decline and premature death equal to or exceeding the risk from obesity[5,6]; and

Whereas, Increased meaningful daily interactions and multiple sources of social support are associated with decreased loneliness[3,7]; and

Whereas, Decades of research provide evidence for the strong causal relationship between social relationships and health and longevity[8]; and

Whereas, The United Kingdom has recognized loneliness as an epidemic and has appointed a Minister of Loneliness to address loneliness in the UK, directed federal funding towards expanding the Shared Lives program, and encourages physicians to offer "social prescribing" to connect patients with community activities[9,10]; and

Whereas, The American Psychological Association, the National Academies of Science, Engineering, and Medicine, former Surgeon General Vivek Murthy, and many other health organizations have publicly spoken out about loneliness as a public health problem in the US[11-13]; and

Whereas, Our AMA has passed policy to publicly recognize the association between senior suicide and loneliness (H-25.992) and the negative effects of solitary confinement on imprisoned juveniles (H-60.922, 140.029MSS), but no policy exists addressing loneliness as a public health issue affecting people of all ages; therefore be it

RESOLVED, Our AMA releases a statement identifying loneliness as a public health issue with consequences for physical and mental health; and

RESOLVED, Our AMA supports efforts to combat loneliness.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY:

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Health Care for Older Patients H-25.999
The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.

Policy Recommendations in the Field of Aging H-25.998
It is the policy of the AMA that: (1) Older individuals should not be isolated; (2) a health maintenance program is necessary for every individual; (3) more persons interested in working with older people in medical and other professional fields are needed; (4) more adequate nursing home facilities are an urgent health need for some older people in many communities; (5) further development of service and facilities is required; (6) extension of research on both medical and socioeconomic aspects of aging is vital; (7) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and (8) local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.

Increased Liaison, Communication and Educational Efforts with the Elderly H-25.994
The AMA supports (1) increasing communications and understanding between organized medicine and the elderly; (2) continuing contact with organizations such as the AARP, offering speakers for their meetings, and pursuing other steps to improve their understanding of physicians' problems and concerns; and (3) encouraging state and county medical societies to undertake similar efforts to increase liaison with the elderly.

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Financing of Long-Term Services and Supports H-280.945
Our AMA supports: (1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability; (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities; (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy; (6) Medicare Advantage plans offering LTSS in their benefit packages; (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit; (8) a back-end public catastrophic long-term care insurance program; (9) incentivizing states to expand the availability of and access to home and community-based services; and (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987
Our AMA, in collaboration with other interested parties, such as the public health community, geriatric specialties, and organizations working to advocate for seniors, will create a repository of available resources for physicians to guide healthy practices for seniors who reside in independent living communities.

Senior Care H-25.993
Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs.

Clinical Preventive Services H-425.984
Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

Solitary Confinement 140.028MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 10
(I-19)

Introduced by: Region 2; Region 3; Region 7

Subject: Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Public assistance programs provide financial assistance to low-income individuals and families to prevent falling below the poverty line due to costs of living, health care, and food[1]; and

Whereas, One in five Americans receives benefits from at least one public assistance program[1]; and

Whereas, Public assistance programs, like the Supplemental Nutrition Assistance Program (SNAP), commonly known as “food stamps,” and the Temporary Assistance for Needy Families (TANF), commonly known as “welfare,” provide financial assistance to low-income individuals and families to address domestic hunger and similar basic needs[2-3]; and

Whereas, SNAP and TANF are partnerships where federal and state governments share administrative responsibilities and expenses for beneficiaries[2,3]; and

Whereas, SNAP usage is associated with improved nutrition, lower cost of health care among recipients, and reduced risk for several chronic medical conditions including coronary artery disease, cancer, asthma, and diabetes[4]; and

Whereas, Resource limitations and stringent requirements, such as federal law which requires all TANF recipients work for a minimum of 30 hours per week or 20 hours per week for single parents with children under the age of 6 years, prevent TANF from benefiting many low-income families[3,6]; and

Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation in employment and training programs for certain adults aged 18 to 59[5]; and
Whereas, Efforts to increase work requirements for recipients of public assistance programs can have negative effects on recipients’ health outcomes and limit their ability to find stable employment[6-7]; and

Whereas, Many recipients register for public assistance programs only after losing employment, and more than 80 percent report securing employment within a year after starting to receive SNAP benefits[6-7]; and

Whereas, Increased work requirements to qualify for public assistance programs create administrative barriers that prevent even working recipients from receiving benefits, and have the potential to restrict coverage for those with chronic medical conditions, including mental illness and substance abuse disorders[6-8, 17]; and

Whereas, Increased work requirements to qualify for public assistance programs are not shown to improve health outcomes or reduce employment barriers[6,9]; and

Whereas, Both federal and state governments share authority over work requirements for public assistance programs, and states can exempt recipients from federal work requirements at their discretion to allow more individuals to benefit from public assistance programs[2,5,10]; and

Whereas, Our AMA opposes work requirements for the public assistance program Medicaid[11]; and

Whereas, In a 2018 letter to the US Senate, our AMA expressed its support for the preservation of SNAP and opposed proposed increases in work requirements that would reduce benefits for recipients[12]; and

Whereas, While AMA undertook this action, existing policy on SNAP is vague, stating that "Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives" and does not explicitly describe our opposition to increasing work requirements[13]; and

Whereas, In 2019, the US Department of Agriculture considered new regulations that would remove SNAP benefits from hundreds of thousands of recipients, by preventing states from (1) exempting recipients from SNAP work requirements, (2) expanding SNAP eligibility standards beyond the federal minimum, and (3) automatically qualifying individuals for SNAP based on TANF eligibility, all of which are efforts taken by states to expand benefits to more low-income individuals[14-16]; therefore be it

RESOLVED, That our AMA support the amendment of AMA policy H-290.961, Opposition to Medicaid Work Requirements, to maintain our nation's social safety net, including public assistance programs such as SNAP and TANF, by insertion as follows:

Opposition to Medicaid Work Requirements H-290.961

1) Our AMA opposes work requirements as a criterion for Medicaid eligibility.
2) <u>Our AMA supports flexibility in work requirements used as a criterion for eligibility for other public assistance programs, such as SNAP and TANF, including, but not limited to, exempting individuals from work requirements in these programs.</u>
3) <u>Our AMA supports the ability of states to expand eligibility standards for public assistance programs beyond federal minimum eligibility standards, including, but not limited to, automatically qualifying individuals for a public assistance program based on their eligibility for another program.</u>

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

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, AMA-MSS Digest of Policy Actions/ 190 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

Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research 150.036MSS
AMA-MSS (1) supports nutrition education programs for Supplemental Nutrition Assistance Program (SNAP) recipients and (2) opposes changes to SNAP that 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

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 11
(I-19)

Introduced by: Region 1; Region 5; Courtney Harris, Chicago Medical School at Rosalind Franklin University

Subject: Standard Procedure for Accommodations in USMLE and NBME Exams

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Americans with Disabilities Act (ADA) section 36.309 requires that any documentation requested by a testing entity in order to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of a candidate's disability and their need for the requested testing accommodations[1]; and

Whereas, Under the ADA section 36.309, examples of legally-appropriate accommodation request documents include: (1) recommendations by qualified healthcare professionals, (2) proof of past testing accommodations, (3) observations by educators, (4) results of psycho-educational or other professional evaluations, (5) an applicant's history of diagnosis, and (6) an applicant's statement of his or her history regarding testing accommodations[1]; and

Whereas, Under the ADA section 36.309, depending on the nature of either the disability, or the form of requested accommodation, a testing entity might only need one or two forms of documentation to verify the nature of the candidate's disability and his or her need for the requested accommodation[1]; and

Whereas, Under the ADA section 36.309, proof of past testing accommodations in similar test settings is generally sufficient to support a request for the same testing accommodations for a subsequent standardized exam or other high stakes test[1]; and

Whereas, Under the ADA section 36.309, if a candidate previously received testing accommodations under an Individualized Education Program (IEP) or Section 504 Plan, they should generally receive the same testing accommodations for a subsequent standardized exam, examples include extra time, additional or extended breaks, testing in a private room, or other sight- or hearing-based accommodation[1,2]; and

Whereas, Under the ADA section 36.309, recognizing the importance of face-to-face evaluation for a correct diagnosis, directs testing entities to give precedence to reports from qualified professionals who have personally evaluated the candidate over reports from testing entity reviewers who did not conduct an assessment of the candidate for diagnosis and treatment[1]; and

Whereas, The National Board of Medical Examiners (NBME) has a practice of reviewing and sometimes denying accommodations requests without a face-to-face evaluation; in *Berger v. the National Board of Medical Examiners*, the NBME denied an accommodation request based on the testimony of NBME-paid outside experts who provided their opinions without having

evaluated the candidate; this practice violates the ADA's requirement of deference to the opinions based on in-person evaluations[1,3]; and

Whereas, The ADA section 36.309, states a qualified professional's decision not to provide results from a specific test or evaluation instrument should not preclude approval of a request for testing accommodations where the documentation provided by the candidate, in its entirety, demonstrates that the candidate has a disability and needs a requested testing accommodation[1]; and

Whereas, According to the ADA section 36.309, a testing entity must respond in a timely manner to requests for testing accommodations, including when that entity requests additional information, to ensure equal opportunity for applicants with disabilities to register and take the test in the same testing cycle as their classmates as to not delay their medical education[1]; and

Whereas, According to the ADA section 36.309, failure by a testing entity to act in a timely manner, coupled with requests for duplicative, unnecessary, or extraneous documentation, could result in an extended delay such that it denies persons with disabilities equal opportunity or equal treatment as their peers without disabilities[1]; and

Whereas, American College Testing (ACT), which administered the ACT to approximately 1.91 million students in 2018, testing states that requests are normally processed in 10-14 business days[4,5]; and

Whereas, The Law School Admission Council (LSAC), which administered the Law School Admission Test (LSAT) to 138,597 students between June of 2018 and March of 2019, states that students who request the same accommodations that they have received previously will receive those accommodations without further documentation, as long as they provide verification of that previous accommodation for a standardized test and the accommodation does not require administration over multiple days[6,7]; and

Whereas, The United States Medical Licensing Examination (USMLE) website states that the applicant should wait 60 days for processing and requires a personal statement, complete and comprehensive evaluation from a qualified professional done in the past three years, and supporting documentation potentially including academic records, score transcripts for previous standardized exams, verification of prior academic/test accommodations, relevant medical records, previous psychoeducational evaluations, faculty or supervisor feedback, job performance evaluations, and course evaluations[2,8,9]; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education, a book which is written for health science administrators and disability service providers, recommends beginning the accommodation request process 10 months before the planned exam date because in the context of a rigorous medical education program, it takes months to put together the requested documentation, write a personal statement, account for 60 days of processing time, and the potential request for further documentation or the time for an appeal after a denial, both of which can take further months of processing time[2]; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education states that the assessments that students often need for accommodations cost between $1,200 to more than $5,000 dollars depending on health insurance and geographic location[2]; and

Whereas, A study by the Association of American Medical Colleges and the Human Resources Research Organization found that medical students who received extended time on the Medical College Admission Test (MCAT) had no difference in either MCAT scores or in rates of admission to medical school, and even after they controlled for undergraduate GPA, the students who had received MCAT accommodations had between 8.1% to 18.9% lower graduation rates based on the number of years it took to graduate and an 11%, 9%, and 5% lower pass rate on Steps 1, 2 CK, and 2 CS respectively[10]; therefore be it

RESOLVED, That our AMA will collaborate with the National Board of Medical Examiners to release the percentages of accommodations requests that are approved, modified, and denied, to establish a better understanding of why medical students with disabilities graduate from medical school at lower rates; and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, will develop a plan to create a faster timeline for the processing of student accommodation requests than currently exists for exams administered by the United States Medical Licensing Examination, to better allow students with disabilities to take their exams at the same time as their abled classmates; and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, will develop a plan to reduce the amount of extraneous and duplicative proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities; and be it further

RESOLVED, That our AMA will advocate for the National Board of Medical Examiners to defer to the expertise of qualified professionals that have personally assessed the student when making accommodation determinations instead of relying on outside experts who have not personally assessed the student.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Accommodating Lactating Mothers Taking Medical Examinations H-295.861
Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. Reaffirmation A-16

Advocacy for Physicians with Disabilities D-90.991
1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. Res. 617, A-19

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws. Res. 220, I-17

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines. Res. 705, A-13

A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929
Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training. Res. 317, A-19

Improving Support and Assistance for Medical Students with Disabilities 310.055MSS
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)

Combating Sex-Linked Discrimination of Denying Special Request for Lactation during Medical Board Examination 295.183MSS
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, A14) (Substitute AMA Res 903, I-14 Adopted with Change in Title [H-295.861])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 12
(I-19)

Introduced by: Region 2; Region 4; Region 5

Subject: Promoting Early Access to Diabetes Care to Reduce the Incidence of End-Stage Renal Disease

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Social Security Amendments of 1972 extended Medicare eligibility through the End Stage Renal Disease (ESRD) Program to cover any patient, regardless of age, who is diagnosed with ESRD[1-2]; and

Whereas, The prevalence of ESRD has dramatically and steadily increased from 72.7 to 208.7 cases per one hundred thousand US residents from 1990 to 2015, driven largely by an increase in the prevalence of the leading cause of ESRD, diabetic nephropathy[3-4]; and

Whereas, The national burden of Chronic Kidney Disease increased by 52.6% from 1,269,049 Disability-Adjusted Life Years (DALYs) to 1,935,954 DALYs from 2002 to 2016[5]; and

Whereas, Studies have found that as a result of poorly managed chronic hyperglycemia, 4-17% percent of patients with diabetes mellitus (DM) will develop ESRD within 20 years [6-7]; and

Whereas, Chronic poor glycemic control in DM is highly associated both with acute complications and long-term morbidity and mortality from cardiovascular and kidney disease[8-9]; and

Whereas, The cost of insulin is currently a significant barrier to glycemic control in DM, with an estimated 24 - 30 % of diabetic patients rationing their insulin for financial reasons[10-11]; and

Whereas, The cost of testing equipment poses an additional barrier to glycemic control in DM, with a reported 38.6% of US patients with Type 1 DM reporting rationing their testing equipment[12]; and

Whereas, The cost of non-insulin antihyperglycemic medications pose additional barriers to adherence for patients, especially those underinsured; and

Whereas, It costs on average $5,705 to provide a year's supply of insulin and $4,119 to provide a year's supply of non-insulin medications to help a patient with diabetes achieve good glycemic control, which can prevent progression to chronic kidney disease[13]; and

Whereas, It costs $89,000 to provide one year of ESRD care to a patient with advanced diabetic nephropathy, leading to an enormous total of $35.4 billion paid by Medicare in 2016, a 4.6% rise from the previous year[1]; and

Whereas, Patients with well-controlled diabetes are much less likely to progress to advanced diabetic nephropathy and ESRD in the long term, and thus enjoy a far superior quality of life[14]; and

Whereas, Guaranteeing access to insulin, non-insulin antihyperglycemic medications, and glucose-monitoring equipment to all patients regardless of their age would remove significant financial barriers to good glycemic control and therefore lower the risk of progression to ESRD in underinsured patients; and

Whereas, Patients of any age who have ESRD are eligible for Medicare, but only ensures patients with diabetes of ages 65 and older, despite poorly controlled diabetes being a leading cause of ESRD; therefore be it

RESOLVED, That our AMA shall call upon Congress for the expansion of Medicare Part D to individuals less than 65 years of age with diabetes for the procurement of all varieties of insulin, blood glucose monitoring supplies, and non-insulin antihyperglycemic treatment with the intention of reducing the incidence of End Stage Renal Disease.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

Strategies to Address Rising Health Care Costs H-155.960
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs:
(a) reduce the burden of preventable disease;
(b) make health care delivery more efficient;
(c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Achieving Health Care Coverage for All 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.

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.

Advancing Quality Coordinated Care for Patients with End Stage Renal Disease H-370.957
Our AMA will work with Members of Congress and their staffs to ensure that any legislation which promotes integrated and patient-centered care for End Stage Renal Disease (ESRD) patients does not inappropriately impinge on the patient-physician relationship and is in the best interest of ESRD patients.

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.

Increasing Access to Medical Devices for Insulin-Dependent Diabetics 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 13
(I-19)

Introduced by: Region 4

Subject: Expanding Insurance Coverage to Accommodate Bariatric Surgery in Qualified Individuals

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The CDC reports the prevalence of obesity (BMI greater than 30) in the United States to be 39.8%;[8] and

Whereas, Obesity in the U.S. is associated with chronic disease, impaired quality of life, a 50% higher risk of mortality in persons BMI of 30, doubled mortality rates in persons BMI of 35, and over 300,000 premature deaths;[7] and

Whereas, Obesity increases medical expenses associated with diabetes by 33%, 60% for dyslipidemia, and 58% for hypertension contributing to the over $90 billion and $147 billion in direct and indirect annual healthcare costs, respectively;[7] and

Whereas, Bariatric surgery (including gastric bypass, gastric banding, gastroplasty) can result in substantial weight loss and over the past four decades studies have shown significant decreases in mortality from obesity after these procedures compared to lifestyle modifications and medical therapies alone (25% weight loss vs 10% weight loss, respectively);[7] and

Whereas, Bariatric surgery poses relatively low risk with a 30-day mortality of 0.17 - 0.28%;[3] and

Whereas, 86% no longer needed medications for hyperlipidemia, 81% no longer needed medications for hypertension, 72 - 81% of patients discontinue diabetes medications one-year following surgery, and 50-85% overall undergo complete remission of diabetes;[5, 10] and

Whereas, Several studies have found a dramatic reduction in obstructive sleep apnea symptoms following bariatric surgery;[5, 9] and

Whereas, It would cost approximately $4250 for every year of life added to a 30-45 BMI patient, $4000 for a 35-40 BMI patient, and $3000 for any obese patient with a comorbidity undergoing bariatric surgery (any value below $50,000 is considered cost-effective);[7, 4] and

Whereas, Though mean upfront costs range from $17,000 to $26,000, the investment of surgery is compensated by avoiding long-term comorbidity costs within 2 years of laparoscopic surgery and 4 years of an open bariatric surgery;[1] and

Whereas, More affluent states, with greater access to bariatric surgical services, had lower rates of obesity than less affluent states[2], and

Whereas, Despite relative low risk of surgery, clear reductions of obesity related comorbidities following surgery, and subsequent reductions in overall individual medical costs, insurance companies routinely deny coverage to access this treatment;[7] and

Whereas, The idea that providers who grant coverage to individuals who later switch to a different provider will not reap the long-term savings is one cause of the reluctance;[7] and

Whereas, Various studies have shown between 10 - 47.8% of qualified individuals are initially denied coverage to these surgeries;[3] and

Whereas, Insurance denial is associated increased rates of comorbidities among qualified patients with an estimated 3-fold higher mortality;[3] and

Whereas, Insurance companies also establish significant pre-surgery requirements, despite the lack of evidence for improved outcomes upon meeting these requirements,[6] and

Whereas, Evidence has shown pre-bariatric surgery requirements were associated with decreased patient progression to surgery, increased wait time for surgery, and increased weight gain during said delay;[6] and

Whereas, Existing AMA policy recognizes obesity as a disease (H-440-842) and as a major health concern (H-440.902); and

Whereas, Existing AMA policy also advocates for increased patient access to evidenced-based treatment modalities such as surgery; and

Whereas, Existing AMA-MSS policy recognizes obesity as a chronic disease (440.013MSS) and childhood obesity as a public health epidemic (440.018MSS); therefore be it

RESOLVED, That our AMA advocate and support the implementation of policy that mandates all insurance companies provide bariatric surgery coverage to qualified individuals including but not limited to those with a BMI over 40 with significant comorbidities.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Recognition of Obesity as a Disease H-440-842
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Obesity as a Major Health Concern H-440.902
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.

Addressing Obesity D-440.954
Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician

payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

Obesity as a Chronic Disease 440.013MSS
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 Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Childhood Obesity as a Public Health Epidemic 440.018MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 14
(I-19)

Introduced by: Region 1; Region 7; Lekha Chilakamarri, University of Texas Rio Grande Valley School of Medicine

Subject: Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Over 90% of physicians surveyed in 2006 rated political involvement and collective advocacy as important[1]; and

Whereas, National physician voter registration rates have been documented as high as 94%[2]; and

Whereas, A study of residents and fellows suggests that up to 88% may be registered to vote[3]; and

Whereas, Despite high rates of voter registration, physician voter turnout suggests that physicians vote at a rate that is 9% lower than that of the general population and 22% lower than that of lawyers[4]; and

Whereas, In a survey of residents and fellows, 94% agreed that they had the duty to advocate, yet less only 13% felt comfortable influencing legislation on a particular legislative issue[3]; and

Whereas, Therefore, the importance that physicians place on voting is reflected in voter registration rates, but not in the act of voting itself- suggesting a need to further study voter participation and barriers to turnout in the House of Medicine; and

Whereas, Among the general public, several initiatives show promise in increasing turnout such as statewide portable voter registration which can increase voter turnout by 2.4% points, election day registration which can increase voter turnout by 3-6 percentage points, and the institution of mail-in ballots in Oregon which resulted in a 10% increase in voter turnout in both presidential and midterm elections[5,6,7]; and

Whereas, Current AMA policy supports education of medical trainees on health policy, advocacy, and legislative issues that affect medical trainees and physicians (H-295.953); and

Whereas, the AMA endorses identifying efforts to engage physicians and medical trainees in legislative advocacy (G-615.103), the physician and medical trainee's right to engage in patient advocacy (H-285.910, H-225.950), as well as the fundamental importance of advocacy in the physician-patient relationship (H-225.950); and

Whereas, As a result of policy G-615.103, the Academic Physicians Section is studying the engagement of members in the House of Delegates and our AMA is studying "behavioral trends" of its members and of specialty societies, yet no efforts are focused on identifying and alleviating barriers to medical student, resident/fellow, and physician voting[8]; therefore be it

RESOLVED, That our AMA amend policy G-615.103 by addition and deletion, as follows:

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy, G-615.103

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine, ~~and~~ legislative advocacy, and voting in federal, state, and local elections;

(2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine, ~~and~~ legislative advocacy, and voting in federal, state, and local elections;

(3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine, ~~and~~ legislative advocacy, and voting in federal, state, and local elections.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103
Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:
Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities H-310.911
Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy.

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated

against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal

issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
4. Hospital Medical Staff Relations
a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.
5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay

administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

295.029MSS: Medical Student Legislative Awareness

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)

310.021MSS: Promoting Resident Involvement in Organized Medicine
Promoting Resident Involvement in Organized Medicine: AMA-MSS encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and organized medicine conferences. (MSS Sub Res 13, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 15
(I-19)

Introduced by: Region 2; Region 4

Subject: Studying an Application cap for the National Resident Match Program

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The number of residency applications submitted per student to the National Resident Match Program (NRMP) has dramatically increased over the last decade (increasing by 73% for US Graduates and 44% for Total Active Applicants since 2009), despite modest increases in the number of residency positions per applicant during the same period (19% increase for US seniors and a 9% increase for total active applicants)[1-5]; and

Whereas, Completing large volume of Electronic Residency Application Services (ERAS) submissions poses a considerable burden on medical students' time and financial resources, with some studies suggesting that students pay an average of $4,000-6,000 on the interview process[3,5,11,16-20]; and

Whereas, The total number of residency applications processed by residency programs has increased by 26% between 2010 and 2018, which has led many program directors to increasingly rely on screening metrics (GPA, United States Medical Licensing Examination (USMLE) Step scores, class rank, etc.) in an effort to reduce this application burden[1,3,5-12]; and

Whereas, Only 47% of all applications submitted through ERAS receive an in-depth review, and there has been a 7.1% increase over the last 10 years of residency programs using a target USMLE Step 1 score for interview offer selections[21]; and

Whereas, Existing AMA policy urges that the USMLE scores not be used as the sole criteria for selecting interns and residents, and recommends that residency programs consider all of the candidates attributes and qualifications during the selection process, as well as continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises (H-255.980, USMLE Scores not Sole Criteria for Residency Selection, D-310.977, National Resident Matching Program Reform); and

Whereas, The increasing emphasis on USMLE Step 1 scores has led to many unintended consequences that may negatively impact medical students' wellness in their undergraduate medical education, such as the emotional stress associated with high-stakes exams, the financial burden of purchasing multiple third-party resources, and limitations on enacting new and innovative curricula in undergraduate medical education[3,8-10,13-15]; and

Whereas, Important stakeholders of the USMLE convened an Invitational Conference on USMLE Scoring (InCUS) in response to many of the aforementioned problems with one of their

preliminary recommendations mentioning that limiting the number of residency applications that an individual can submit per match cycle should be considered[22]; and

Whereas, There is growing support from residency program directors and other medical educators for ERAS application limits within the Match process[3,5,7,11]; therefore be it

RESOLVED, That our AMA study the implementation of application limits for the National Resident Matching Program through the Electronic Residency Application Services as a means of addressing the increase in residency application volume on individual residency programs.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
CME Rep. 4, A-05 Appended: Res. 330, A-11 Appended: Res. 920, I-11 Appended: Res. 311, A-14 Appended: Res. 312, A-14 Appended: Res. 304, A-15 Appended: CME Rep. 03, A-16 Reaffirmation: A-16 Appended: CME Rep. 06, A-17 Appended: Res. 306, A-17 Modified: Speakers Rep. 01, A-17

Policy Suggestions to Improve the National Resident Matching Program D-310.974
Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National

Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.
CME Rep. 15, A-06 Appended: Res. 918, I-11 Appended: CME Rep. 12, A-12

USMLE Scores not Sole Criteria for Residency Selection H-255.980
Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications.
Res. 143, A-90 Appended Res. 303, I-98 Modified and Reaffirmed: CME Rep. 2, A-08 Modified: Speakers Rep. 01, A-17 Reaffirmed: CME Rep. 01, A-18

Fairness in the National Resident Matching Program 295.069MSS
AMA-MSS will ask the AMA to remain committed to ensuring a fair residency selection process that works to accommodate students' best interests. Reaffirmed: MSS GC Report A, I-16

Transparency in the NRMP Agreement 295.162MSS
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. Reaffirmed: MSS GC Report A, I-16

Addressing the Increasing Number of Unmatched Medical Students 310.050MSS
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 16
(I-19)

Introduced by: Region 3; Region 7

Subject: Revising the Social Support Criterion of Organ Transplant Waitlist Eligibility

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States national organ transplantation waiting list exists due to the worsening discrepancy in the number of those in medical need of organ transplantation and the number of organs available for transplant[1-12]; and

Whereas, Numerous individuals experience severe consequences from not receiving an organ in a timely manner, resulting in 20 deaths each day for people on the national organ waitlist, alone[1-4,13-19]; and

Whereas, Discriminatory criteria and practices in organ transplantation eligibility are prohibited in the United States regardless of waitlist length[20-24]; and

Whereas, Many people are rejected from waitlist placement despite demonstrated medical need[25-27]; and

Whereas, Sufficient social support is a national eligibility criterion for organ transplant candidacy set by the United States Department of Health & Human Services' Ethical Principles in Allocation of Human Organs, Allocation and Access section, stating, "Factors relevant to access to the transplant waiting list, as distinguished from medical criteria used in equitable allocation of organs, include: …psychosocial factors (e.g., financial and social support, patient support)," meaning that potential recipients should have adequate social support to promote successful uptake of the organ[20,28]; and

Whereas, There is some evidence supporting the notion that potential organ transplant recipients are more likely to have successful post-operative outcomes with higher levels of social support, leading to associated aforementioned policy in the United States, despite the relative old age of the studies[29-36], and

Whereas, Many other developed nations, such as Canada and constituent countries of the European Union, reject implementing such a policy due to strong evidence indicating that social support levels do not impact organ transplant outcomes[37,38]; and

Whereas, Transplant centers consistently require patients' suitability for transplantation to be evaluated by either a psychiatrist, psychologist, or social worker; patients are not listed on the organ transplant list unless approved by one or more of these professionals[39,40]; and

Whereas, The factor of social support greatly influences physicians who are deciding patients' organ transplantation candidacy, which may exacerbate existing racial, income-related, and geographic transplant disparities[28,39,41-43]; and

Whereas, As many as 42.4 percent of United States physicians are not confident in how to best use and evaluate social support to determine transplant eligibility, which is associated with the non-uniform implementation of this criterion in practice[39,44,]; and

Whereas, Transplant providers from 202 health centers in the United States estimated that as many as 9.6 percent of patients evaluated in the prior year were excluded due to inadequate social support[39,44]; and

Whereas, Rejection from or, otherwise, not being placed on the waitlist disproportionately affects African-American, Asian, Hispanic, low-income and rural populations, in part due to the social support criterion[45-52]; and

Whereas, Existing AMA Code of Ethics and Policy (H-370.982, H-370.990) demonstrates that the AMA has supported organ allocation policies and practices that result in equitable treatment and standardized evaluation of potential candidates that are not based on non-medical criteria to avoid undue discrimination[28]; and

Whereas, 69.2 percent of United States physicians supported revised guidelines for this social support criterion[39]; and

Whereas, There are several medical bodies, including the American Society of Transplantation, the American Society of Transplant Surgeons, and the Society for Transplant Social Workers, that have recognized the need for greater development of the social support criterion and are working on developing improved guidelines and evaluation tools, such as the Stanford Integrated Psychosocial Assessment for Transplant (SIPAT) [53-55]; and

Whereas, The medical repercussions of the growing waitlist for organ transplantation neither merit the abuse of this vague social support criterion, nor outweigh the ethical obligations of physicians[28]; therefore be it

RESOLVED, That our AMA encourages revision of the adequate social support criterion by improving this policy's clarity and specifications for organ transplant eligibility, such as by specifying certain objective social metrics that would more systematically identify patients who should be excluded from the waitlist, with the aim of mitigating racial, income-related, and geographic disparities in transplantation eligibility; and be it further

RESOLVED, That our AMA supports programs that educate and train medical professionals who assess patient transplant eligibility in the standardized evaluation of patients' social support for objective determining transplant recipient eligibility, as informed by evidence- and team-based practices and tools, as agreed upon by specialty societies and other stakeholder organizations involved in transplant capacity assessment, that are not discriminatory with regard

to race, income and geography to better establish more equitable national, regional, and healthcare system-specific organ waitlist placement.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

The Physician's Role in Organ Donation D-370.997
Our AMA will continue to promote organ donation awareness.
CSA Rep. 6, A-00 Modified: CSAPH Rep. 1, A-10

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.
CLRPD 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

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.
BOT Rep. 15, A-13

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18

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.
(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.
CEJA Rep. K, A-93 Reaffirmed: CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 6, A-00Appended: Res. 512, A-02 Reaffirmed: CEJA Rep. 3, A-12

Transplantable Organs as a National Resource H-370.990
Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy.
Res. 94, I-87 Reaffirmed: Sunset Report, I-97 Appended and Reaffirmed CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

6.1.1 Transplantation of Organs from Living Donors
Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.
Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.
Physicians who participate in donation of nonvital organs and tissues by a living individual should:

(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor's well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
(i) the minor agrees to the donation;
(ii) the minor's legal guardians' consent to the donation;
(iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:
(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
(j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.
(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
(l) Permit living donors to designate a recipient, whether related to the donor or not.
(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
(ii) domino paired donation;

(iii) non-simultaneous extended altruistic donation (“chain donation”).
(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.
Issued: 2016

6.2.1 Guidelines for Organ Transplantation

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician’s primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.
Physicians who participate in transplantation of organs from deceased donors should:
(a) Avoid actual or perceived conflicts of interest by ensuring that:
To the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death.
No member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.
(b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
(c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.
(d) Ensure that the prospective recipient (or the recipient’s authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.
(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.
(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.
(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

6.2.2 Directed Donation of Organs for Transplantation

Efforts to increase the supply of organs available for transplant can serve the interests of individual patients and the public and are in keeping with physicians’ obligations to promote the welfare of their patients and to support access to care. Although public solicitations for directed donation—that is, for donation to a specific patient—may benefit individual patients, such solicitations have the potential to adversely affect the equitable distribution of organs among patients in need, the efficacy of the transplant system, and trust in the overall system.

Donation of needed organs to specified recipients has long been permitted in organ transplantation. However, solicitation of organs from potential donors who have no pre-existing relationship with the intended recipient remains controversial. Directed donation policies that produce a net gain of organs for transplantation and do not unreasonably disadvantage other transplant candidates are ethically acceptable.
Physicians who participate in soliciting directed donation of organs for transplantation on behalf of their patients should:
(a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.
(b) Support the development of evidence-based policies for solicitation of directed donation.
(c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.
(d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.
(e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
(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)

Protecting Equity in Access to Kidney Dialysis and Transplant and Advocating for Patients' Best Interest in End Stage Renal Disease 370.018MSS
AMA-MSS support 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, Res 66 I-17)

Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant 370.014MSS

AMAMSS 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 17
(I-19)

Introduced by: Region 2; Region 3; Region 4; Region 7

Subject: Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Free and affordable sharing of research data among scientists has been shown to confer numerous benefits in the advancement of scientific progress[1,2,3]; and

Whereas, Limited data sets are defined as those registries and databases that adhere to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are stripped of all direct patient identifiers and protected health information (PHI)[4,5]; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) currently maintains de-identified limited data sets that contain outcome, demographic, comorbidity, and cost data for millions of patients across the United States, which have been instrumental in conducting high-quality, population-wide research[6,7,8]; and

Whereas, Many of these data files, which are already subsidized by taxpayer dollars, can cost tens of thousands of dollars per year of data to acquire, an expense that poses a significant financial barrier to academic and non-profit organizations[6,9]; and

Whereas, There is currently no written justification for these prices on the CMS website[6,10,11]; and

Whereas, Increasing academic and non-profit access to larger datasets for scholarly purposes would greatly increase the sample size, relevance and power of future studies; and

Whereas, Lowering the cost of this data for academic and non-profit users, and offsetting the resulting loss in revenue with increased prices for for-profit and corporate entities, would aid in increasing access to this data for research purposes[9]; and

Whereas, Such a tiered pricing scheme (i.e. higher prices for commercial users and lower prices for non-commercial users) has already been implemented in other countries such as the United Kingdom[12,13]; therefore be it

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use, such as by creating a two-tier pricing system.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Medicare Claims Data Release D-406.993
Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; (2) engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs; and (3) petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public.

Work of the Task Force on the Release of Physician Data H-406.990
Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health

care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:

    (a) the publication or release of this information is deemed imperative to safeguard the public welfare;

    (b) the raw data regarding physician claims from governmental healthcare programs is:

        (i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.

        (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.

    (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:

(i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the AMA-convened Physician Consortium for Performance Improvement.
(iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.

(d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to the their use, publication or release.

Availability of Professionals for Research H-460.982

(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers.
(2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students.
(3) The current annual production of PhDs trained in the biomedical sciences should be maintained.
(4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased.
(5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support.
(6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions.
(7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review.
(8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent.

(9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.

Medical Information and Its Uses H-406.987

Data Transparency Principles to Promote Improvements in Quality and Care Delivery

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 18
(I-19)

Introduced by: Region 4

Subject: Empowering Patients and Upholding Compliance with Healthcare Price Transparency via Actionable Enforcement Tools, & Amending D-155.987, Price Transparency

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Opaque pricing structures may benefit powerful special interest groups, such as large hospital systems and insurance companies, but they generally leave patients and taxpayers worse off than would a more transparent system[1-13]; and

Whereas, On June 24th, 2019, the Executive Office of the President [Donald Trump] issued the Executive Order 'Improving Price and Quality Transparency in American Healthcare to Put Patients First' to address "the issue that patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care"[1]; and

Whereas, The order mandates that hospitals report their chargemaster prices[1]; and

Whereas, The order, at this point in time, fails to disclose a means of: 1) verification, 2) enforcement, or 3) penalties for non-compliance regarding patient accessibility or usability of chargemaster prices[1, 13-16]; and

Whereas, Listed standard charge data are not helpful to patients for determining their out-of-pocket cost for a particular service or facility encounter as there are drastic differences between each hospital's chargemaster prices, amount paid by insurers, and amount paid by the patient[1, 14-24]; and

Whereas, Recent reports revealed that patients with private insurance pay up to 209 percent of Medicare rates despite receiving similar quality of care for the same medical procedures[18-27]; and

Whereas, The Center for American Progress (CAP) estimated that hospitals receive on average 134 percent of Medicare rates across their main payers, despite the assertion that current Medicare rates are designed to cover the costs that "reasonably efficient providers would incur in furnishing high-quality care" [19-25, 29-31]; and

Whereas, The Medicare Payment Advisory Commission (MedPAC) notes in its March 2019 report to Congress that current Medicare payments exceed the marginal cost of caring for Medicare patients by 8 percent[28-31]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) strongly supports the Executive Order and advocates that, "the proposed rule proposes price transparency requirements that will increase competition among all hospitals by requiring them to make pricing information publicly available. As a result, patients would be able to shop for health care that meets their needs and budgets" [15-16, 32-34]; and

Whereas, On July 29th, 2019, the CMS took bold action to implement key elements of the Executive Order by announcing that in order to ensure hospital compliance with the proposal requirements, "the rule proposes new enforcement tools including monitoring, auditing, corrective action plans, and civil monetary penalties of $300 per day" [15-16, 32-34]; and

Whereas, The CMS proposed additional revisions for determining Medicare payment under the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgery Center (ASC) Payment System in calendar year 2020 that align with the new price transparency rule by "mak[ing] public standard charges on the Internet in a machine-readable file" and "mak[ing] public payer-specific negotiated charges for common shoppable services in a manner that is consumer-friendly" [32,34]; and

Whereas, Current profiting entities of the unjust system are advocating to maintain the status quo—the American Hospital Association (AHA) released a critical statement of the CMS proposal as "fuel[ing] anticompetitive behavior among commercial health insurers" and "exceed[ing] the Administration's legal authority and should be abandoned" despite the CMS citing that the Public Health Service Act gives it the authority to put these requirements on hospitals, while the America's Health Insurance Plans (AHIP) demonstrated overall disapproval of the Executive Order, stating that "publicly disclosing competitively negotiated, proprietary rates will reduce competition and push prices higher–not lower–for consumers, patients, and taxpayers"[35-39]; and

Whereas, MedPAC validated the benefit of cost transparency by revealing that hospital systems that face greater price pressure with transparent costs operate more efficiently, and in fact have lower costs[20,28]; and

Whereas, The proposed CMS policy is "estimated to save $160 million for beneficiaries by lowering their copayments and save the Medicare program an estimated $650 million in 2020" [32-34]; and

Whereas, Our AMA supports improvement of price transparency aligns with the following AMA Strategic Focus Areas and MSS Internal Policy Objectives: Increased Health Insurance Access, Health Care Reform, Advancing the Healthcare Profession, Cultivating The Delivery Of Equitable Healthcare To Diverse Patient Populations In A Dynamic Environment[40]; therefore be it

RESOLVED, That our AMA: (a) advocate for the implementation of policy that support monetary penalties for hospitals and other healthcare provider organizations that fail to comply with public price transparency listings; (b) advocate for the establishment of actionable enforcement tools including monitoring, auditing, incentivizing price compliance and efficient healthcare services, and developing corrective action plans; (c) actively engage with stakeholders to ensure compliance with healthcare price transparency; (d) support healthcare price transparency legislation that increases competition among all hospitals, improves patient accessibility to public pricing information, and ensures accountability and integrity of our American healthcare system (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy D-155.987, Price Transparency, to include online hospital price listings and price comparison metrics to compare coverage between different insurance providers and health plans by insertion as follows:

Price Transparency, D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs, as well as price comparison tools between different health care plans and different insurance providers to elucidate gaps in coverage in a manner that is accessible to the general public.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
8. Our AMA advocates for real-time public listings on the Internet of standard procedure charges for every hospital in a machine-readable file to increase ease of accessibility to important cost information.
9. Our AMA advocates for public listings of payer-specific negotiated charges for common shoppable services—services that can be scheduled by a health care consumer in advance—in a manner that is consumer-friendly, easily searchable, written in ‘plain language’, and grouped with charges for common ancillary services.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Medical Information and Its Uses H-406.987

Data transparency principles to promote improvements in quality and care delivery:
Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Relationship of Hospital Costs and Hospital Charges H-240.999
Our AMA urges hospitals: (1) to adopt pricing policies which will more specifically relate the charge for a given item or service to the actual cost of that item or service, including an adequate profit margin;
(2) to inform the medical staff and the public of the rationale for charges which cannot be strictly related to costs;
(3) to inform medical staffs as quickly as possible of any changes in prices; and
(4) to standardize their nomenclature for services, and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison.

Pharmaceutical Costs, H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

Prescription Drug Price and Cost Transparency, D-110.988
1. Our AMA will continue implementation of its Truth-in-Rx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the Truth-in-Rx grassroots campaign.

Price of Medicine, H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Price Transparency, D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Hospital Consolidation, H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Integration of Drug Price Information into Electronic Medical Records / Barriers to Price Transparency / Bidirectional Communication for EHR Software and Pharmacies / Health Plan, Pharmacy, Electronic Health Records Integration, D-478.963
Our AMA will collaborate with other interested stakeholders to: (1) explore (a) current availability and accessibility of EHR, pharmacy and payer functionalities that enable integration of price, insurance coverage, formulary tier and drug utilization management policies, and patient cost information at the point of care, (b) at what levels barriers exist to this functionality or access, and (c) what is currently being done to address these barriers; and (2) develop and implement a strategic plan for improving the availability and accessibility of real-time prescription cost information at the point of care.

Price Transparency in Health Care, 155.003MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 19
(I-19)

Introduced by: Region 5

Subject: Expansion of Epinephrine Entity Stocking Legislation

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Up to 5% of the US population has suffered anaphylaxis[1]; and

Whereas, Common triggers of anaphylaxis are food, drugs, venom, and blood products[2]; and

Whereas, 5% to 8% of US children and 2% to 3% of US adults are at risk for anaphylaxis due to food allergy[1]; and

Whereas, Only 40.7% of children and 25% of adults with food allergies have an epinephrine auto-injector prescription[3,4]; and

Whereas, Low rates of epinephrine possession are particularly concerning given that nearly 40% of food-allergic adults reported at least 1 lifetime food allergy–related emergency department visit, and more than half reported a history of 1 or more severe food-allergic reactions[4]; and

Whereas, The prevalence of Penicillin allergy in the US is 10%, with 6.8% suffering from anaphylaxis[5]; and

Whereas, Most deaths from anaphylaxis have been associated with delayed administration of epinephrine[6]; and

Whereas, A study showed that patients who received epinephrine earlier were less likely to be hospitalized compared to those that received it later at the emergency room (17% vs 43%)[7]; and

Whereas, Accidental injections can occur in a variety of circumstances, such as placing the thumb on the tip of the epinephrine auto-injector during administration or children playing with the devices[8]; and

Whereas, While recent data suggests that accidental epinephrine injections and lacerations are a serious concern, these appear to be rare adverse events and usually require limited medical intervention[8]; and

Whereas, To ensure proper treatment of anaphylaxis, epinephrine auto-injectors should always be replaced before they expire[8]; and

Whereas, In situations concerning the safety and efficacy of expired epinephrine, overall, the benefits of epinephrine auto-injectors use outweigh the potential risks of not administering it if no other epinephrine is available[8]; and

Whereas, As of July 2019, 36 states have passed epinephrine entity stocking laws that allow authorized entities defined by each state to obtain and administer epinephrine auto-injectors to individuals undergoing an anaphylaxis reaction[9]; and

Whereas, All authorized entities with possession of epinephrine auto-injectors are required to complete any certification and training requirements set forth by their state health department[10]; and

Whereas, Completion of certification requirements for epinephrine auto-injectors typically protects the entity, employees of the entity, and healthcare providers prescribing epinephrine of any subsequent liabilities[10]; and

Whereas, The passage of an epinephrine entity stocking law in Michigan was cited as a reason for the University of Michigan to have onsite auto-injectable epinephrine in their dining halls starting in fall 2019[11]; and

Whereas, Following the passage of the Emergency Allergy Treatment Act in Florida, multiple Disney resorts implemented the stocking of epinephrine auto-injectors in 2014[12,13]; and

Whereas, Individual states have defined authorized entities differently[10]; and

Whereas, Many states have defined authorized entities broadly, such as the state of Florida that has defined one as “an entity or organization at which allergens capable of causing anaphylaxis may be present”[10,12]; therefore be it

RESOLVED, That our AMA encourage the adoption of laws in all 50 states that allow authorized entities deemed by each state to permit the storage of auto-injectable epinephrine for use in case of an emergency.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Decreasing Epinephrine Auto-Injector Accidents and Misuse H-115.968
Our AMA: 1) encourages physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and 2) encourages improved product design and labeling of epinephrine auto-injectors.

Food Allergic Reactions in Schools and Airplanes H-440.884
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.

Preventing Allergic Reactions in Food Service Establishments D-440.932
Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to

remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

Over-the-Counter Inhalers in Asthma H-115.972
Our AMA will send a letter to the US Food and Drug Administration (FDA) expressing: 1) our strong opposition to FDA making the decision to allow inhaled epinephrine to be sold as an over-the counter medication without first soliciting public input; and 2) our opposition to the approval of over-the-counter sale of inhaled epinephrine as it is currently not a recommended treatment for asthma.

Allergic Reactions in Schools and Airplanes 150.012MSS
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.

Decreasing Epinephrine Auto-Injector Accidents and Misuse 120.008MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 20
(I-19)

Introduced by: Region 1; Justin Magrath, Tulane University School of Medicine

Subject: Advancing the Role of Outdoor Recreation in Public Health

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Mental illness and chronic diseases are extremely prevalent in the United States with suicide, heart disease, and diabetes among the leading causes of death[1-3]; and

Whereas, Outdoor recreation, defined as outdoor leisure time that occurs in urban, human made, and/or natural environments involving elements of nature such as terrain, plants, wildlife, and water bodies, has been shown to positively impact physical, mental, and social health[4-17]; and

Whereas, Outdoor recreation is associated with decreased risk of cardiovascular mortality and myopia[7,8]; and

Whereas, Compared to recreation in a non-natural environment, recreation in a natural outdoor environment resulted in a 13.4-15.8% decrease in salivary cortisol levels and a 1.7-1.9% reduction in systolic blood pressure[9]; and

Whereas, A 2018 Oregon study estimated that participation in outdoor recreation produces between $735 million and $1.4 billion in savings per year related to chronic disease[10]; and

Whereas, Outdoor recreation can enhance well-being, happiness, and quality of life and improve symptoms related to depression, stress, and PTSD, particularly amongst veterans[11-17]; and

Whereas, The National Recreation and Park Association and the CDC recognize the importance of outdoor recreation to public health and support improving access to recreation opportunities and continuing research efforts[18,19]; and

Whereas, Public spaces available for outdoor recreation are increasingly threatened by decreased public availability due to oil and gas leases and the impacts of climate change[20-22]; and

Whereas, National park visits increased 16% between 2013 and 2018 while discretionary and maintenance appropriations have remained stagnant, with nearly $12 billion of deferred maintenance accumulated, a trend consistent across public recreation agencies[23]; and

Whereas, State parks are also affected by decreased spending with parks across Alabama, Montana, Connecticut, Massachusetts, Wyoming, Minnesota, Texas, Utah and other states facing threats of closure and maintenance backlogs[24-28]; and

Whereas, Decreased appropriations for recreation spaces may uniquely impact low-socioeconomic and minority communities that already have lower quality public spaces for recreation, decreased accessibility, and increased rates of space loss, despite these groups disproportionately benefiting from outdoor recreation[28-34]; and

Whereas, With proven health benefits, outdoor recreation is now being considered as a potential clinical tool via park prescriptions and outdoor organization referrals[35]; and

Whereas, Outdoor recreation as therapy has had limited development in clinical application due to insufficient program reach and resources, lack of available recreation spaces, and limited research on the underlying mechanisms, and effective dose and duration[12,36]; and

Whereas, Current AMA policies, including H-470.997 and H-135.973, encourage physical activity and environmental stewardship but do not specifically address outdoor recreation, nor do they include the unique exercise independent benefits and activities attributed to outdoor recreation; and

Whereas, While AMA policy D-470.993 encourages creation of a set type of exercise venues at the local level, this policy does not include many forms of outdoor recreation spaces and activities nor does it consider federal and state management of outdoor recreation spaces; and

Whereas, Our AMA would benefit from clear guidance on how to act on legislation related to outdoor recreation such as H.R. 2435 and S.500/H.R. 1225 which were introduced in the 2019 cycle to expand opportunities for treatment and healing of military veterans through outdoor recreation on public lands and to alleviate the maintenance backlog in National Parks and Public Lands, respectively[37-39]; therefore be it

RESOLVED, That our AMA encourages federal, state, and local governments to create new and maintain existing public lands and outdoor spaces for the purposes of outdoor recreation; and be it further

RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Government to Support Community Exercise Venues D-470.993
Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities.

Exercise and Physical Fitness H-470.997
The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.

American's Health H-440.859
Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits.

Physical Activity Guidelines H-60.979
Our AMA supports the continued expert review and development of national guidelines regarding physical activity for all ages and the dissemination of such guidelines to physicians.

Promotion of Exercise Within Medicine and Society H-470.990
Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate;(2) medical student instruction on the prescription of

exercise;(3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program.

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

Increasing Outdoor Activity to Prevent Myopia Onset and Progression in School Children H-60.913
Our AMA supports efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children.

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Environmental Preservation H-135.972
It is the policy of the AMA to support state society environmental activities by:
(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
(3) maintaining a global perspective on environmental problems;

(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and (5) encouraging state and component societies that have not already done so to create environmental committees.

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Adoption of a Universal Exercise Database and Prescription Protocols for Obesity Prevention 160.013MSS
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.

Adoption of a Universal Exercise Database and Prescription Protocols for Obesity Prevention 440.018MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 21
(I-19)

Introduced by: Region 1; Region 5

Subject: Using X-Ray and Dental Records for Assessing Immigrant Age

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-rays, which together are compared to growth charts to determine the age of an individual[1]; and

Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs, and dental x-rays may not correlate with the true chronological age of an individual due to population and geography-specific factors, including nutritional intake, environmental exposure, and genetics to such an extent that the Centers for Disease Control (CDC) recommends against using hand-wrist radiographs to determine the age of refugees[1,2,3,4,5]; and

Whereas, International records highlight the wide variety in growth charts utilized country to country, in part due to different genetics, nutrition, medical conditions, and environmental exposures[6,7,8]; and

Whereas, The Department of Homeland Security (DHS) and the Department of Health and Human Services (DHHS) will request new skeletal and dental x-ray imaging to establish the age of an individual crossing the border[9]; and

Whereas, According to Food and Drug Administration recommendations, performing x-rays on children comes with greater risk of radiation-related illness and should only be used to answer a clinical question or to guide treatment[10]; and

Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement (ORR), which is part of the DHHS, states that medical images may be used only when no other means of verifying chronological age exist[9,11]; and

Whereas, The DHS handbook states that acceptable documentation to verify chronological age can include official government-issued documents such as a birth certificate, other governments' records, a baptismal certificate, school records, medical records, or other objective documentation with a date of birth listed, and further, that if the immigrant/refugee does not have their birth certificate, that the DHS should take affirmative steps to contact the refugee's home country's relevant record keeping department to verify their birth date[9]; and

Whereas, The DHS handbook directs immigration officers to accept statements by the person in question, their family members, other people who know the person as verifying evidence[9]; and

Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for child age determination and has since decreased their use of age determination exams between the fiscal years of 2016 and 2018 [12,13]; and

Whereas, In 2018, ICE used the fewest number of age determination exams in the past three years, the DHHS was granted nearly 700 age determination exams for those in the care of the ORR, which was almost double the number granted the year before[13]; and

Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are held in adult detention centers while waiting for their cases to be heard and therefore are not held in the least restrictive setting, in violation of the federal government's promise to do so in the Flores Agreement and further restricting their rights under[14]; and

Whereas, Attorneys representing minors report that their clients' supporting documentation was not used and were instead placed in adult detention centers solely based on x-ray images for months until federal judges ruled that ICE and the DHHS could not classify their immigrant clients as adults based solely on imaging[15]; and

Whereas, Adults have been incorrectly classified as minors; one 19-year-old woman immigrating to the U.S. on a fiancée visa was incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months[16]; and

Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare services provided to minor immigrants, both in detention and those held at border patrol stations; and

Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented; therefore be it

RESOLVED, That our AMA will support policy against the use of non-medically necessary dental and bone forensics to assess an immigrant's age by the Department of Homeland Security and the Department of Health and Human Services; and be it further

RESOLVED, That our AMA will promote education among the Department of Health and Human Services, the Department of Homeland Security, and clinicians assisting those agencies on the inaccuracies and variation in different populations of using dental and bone forensics to assess age.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958
Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations 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. Res. 013, A-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) 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; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. Res. 018, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 22
(I-19)

Introduced by: Region 1; Vamsi Potluri, Josh Bilello, Khuong (Zach) Nguyen, University of Texas Medical Branch; Nicole Lee, Western Michigan University School of Medicine

Subject: Improving Research Standards, Approval Processes, and Post-market Surveillance Standards for Medical Devices

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, 32 million Americans, or 1 in 10 Americans, have at least one medical device[1]; and

Whereas, The Food and Drug Administration (FDA) approves the safety and efficacy of medical devices[2]; and

Whereas, A medical device is defined within the Food Drug & Cosmetic Act as "... an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."[2]; and

Whereas, Current policy (H-100.992) only outlines the American Medical Association's position on approval processes for biological drugs, but does not cover medical devices; and

Whereas, The FDA has 3 regulatory classifications of medical devices: Class I, Class II and Class III[3]; and

Whereas, A class II device can be cleared to market by submission and FDA review through the 510(k) exception if that device is substantially equivalent to a predicate device[4,5]; and

Whereas, Declaring a new device as substantially equivalent to a predicate means it is considered safe and effective[6]; and

Whereas, In many cases, predicate devices have never been tested or have not been tested in many years[7]; and

Whereas, Using predicate devices for safety and efficacy standards may not accurately reflect modern performance and safety standards[8]; and

Whereas, The 510(k) exception was originally created in 1976 to streamline the process of reviewing basic clinical items such as surgical gloves and approving newer versions of devices[9]; and

Whereas, At the time, there was an expectation for the Bureau of Medical Devices to create objective performance standards for class II medical devices[10]; and

Whereas, The Bureau of Medical Devices could not create these standards due to budgetary restrictions[11]; and

Whereas, Medical devices cleared through the 510(k) exception comprise more than two-thirds of the products recalled by the FDA for safety concerns[9]; and

Whereas, The Safety of Untested and New Devices Act of 2012 (SOUND Device Act) was an attempt to improve the 510(k) exception[12]; and

Whereas, Despite the SOUND Device Act, multiple 510(k) exceptions have caused safety concerns due to the continued use of predicates; and

Whereas, One example of a safety concern was the approval of the transvaginal mesh device based on a predicate device called ProtoGen Sling from Boston Scientific causing infection and pain in many patients due to the device protruding from the wall of the vagina[13,14]; and

Whereas, Another example of a safety concern was the metal-on-metal hip implants that continued to reach the market based on older predicate devices resulting in metal on metal friction that led to corrosion and caused inflammation, infection, damage and pain to patients [15,16]; and

Whereas, The FDA attempted to improve the 510(k) exception guidelines in 2019, but continues to use predicate devices as a standard for safety and efficacy[17]; and

Whereas, One way to improve medical device standards is to mandate that 510(k) devices demonstrate improved safety and effectiveness compared to marketed devices for the same clinical purpose[17]; and

Whereas, Medical devices may be approved based on low quality research such as small sample sizes or limited follow-up of trials[17]; and

Whereas, One example of low-quality research was the approval of bioresorbable vascular scaffolds based on a non-inferiority trial compared with drug-eluting stents[17]; and

Whereas, Post-approval clinical data showed that the bioresorbable vascular scaffolds had higher adverse outcomes and were eventually removed from the market by the manufacturer[17,18]; and

Whereas, Post-market surveillance is a critical component of medical device safety and effectiveness because: 1) adverse events may not become apparent until the device has been widely disseminated 2) increased emphasis on priority reviews and shortening premarket approval times has decreased the standard of medical device approvals[17,19]; and

Whereas, Current post-market surveillance only identifies a small fraction of adverse events because it is based on mandated reports and passive surveillance[17]; and

Whereas, Post-market surveillance can be improved by giving conditional approval and collecting data[17]; and therefore be it

RESOLVED, That our AMA support the principles that: (a) an FDA decision to approve a new medical device, to withdraw a medical device's approval, or to change the indications for use of a medical device must be based on sound scientific and medical evidence derived from controlled trials and/or post-market incident reports; (b) the evidence for medical devices should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies, as appropriate; (c) expedited programs for medical devices serve the public interest as long as sponsors for medical devices that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile; (d) confirmatory trials for medical devices approved under accelerated approval should be planned at the time of expedited approval; (e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for conducting confirmatory trials; (f) any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a medical device unless the weight of the evidence from clinical trials and/or post-market incident reports prove that the medical device is unsafe and/or ineffective for its labeled indications; and (g) the FDA should make the annual summary of medical devices approved under expedited programs more readily available to the public and consider adding information on confirmatory clinical trials for such medical devices; and be it further

RESOLVED, That our AMA support improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a) make more stringent guidelines for which devices can qualify for the 510(k) exception; (b) Limit the use of predicate devices to modern devices only; (c) mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose; and be it further

RESOLVED, That our AMA support patient and physician education regarding the risks and benefits of medical devices that have been approved through the 510(k) exception; and be it further;

RESOLVED, That our AMA support stronger post-market surveillance requirements including but not limited to conditional approval of devices until sufficient post-market surveillance data can be collected.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Use of Remote Sensing & Monitoring Devices 1.2.9
Sensing and monitoring devices can benefit patients by allowing physicians and other health care professionals to obtain timely information about the patient's vital signs or health status without requiring an in-person, face-to-face encounter. Implantable devices can also enable physicians to identify patients rapidly and expedite access to patients' medical records. Devices that transmit patient information wirelessly to remote receiving stations can offer convenience for both patients and physicians, enhance the efficiency and quality of care, and promote increased access to care, but also raise concerns about safety and the confidentiality of patient information.
Individually, physicians who employ remote sensing and monitoring devices in providing patient care should:
(a) Determine whether using one or more such devices is appropriate in light of individual patients' medical needs and circumstances, including patients' ability to use the chosen device appropriately.
(b) Explain how the device(s) will be used in the patient's care and what will be expected of the patient in using the technology, and disclose any limitations, risks, or medical uncertainties associated with the device(s) and data transmission.
(c) Obtain the patient's or surrogate's informed consent before implementing the device in treatment.
Collectively, physicians should:
(d) Support research into the safety, efficacy, and possible non-medical uses of remote sensing and monitoring devices, including devices intended to transmit biometric data and implantable radio frequency ID devices.
(e) Advocate for appropriate oversight of remote sensing and monitoring devices.

Reprocessing of Single-Use Medical Devices H-480.959
1. Our AMA: (a) 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; (b) 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; (c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.
2. Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

Required Reporting of Adverse Events 8.8
Physicians' professional commitment to advance scientific knowledge and make relevant information available to patients, colleagues, and the public carries with it the responsibility to report suspected adverse events resulting from the use of a drug or medical device.
Mandated pre- and post-marketing studies provide basic safeguards for public health but are inherently limited in their ability to detect rare or unexpected consequences of use of a drug or medical device. Thus spontaneous reports of adverse events, especially rare or delayed effects or effects in vulnerable populations are irreplaceable as a source of information about the safety of drugs and devices. As the professionals who prescribe and monitor the use of drugs and

medical devices, physicians are best positioned to observe and communicate about adverse events.
Cases in which there is clearly a causal relationship between use of a drug/device and an adverse event, especially a serious event, will be rare. Physicians need not be certain that there is such an event, or even that there is a reasonable likelihood of a causal relationship, to suspect that an adverse event has occurred. A physician who suspects that an adverse reaction to a drug or medical device has occurred has an ethical responsibility to:
(a) Communicate that information to the professional community through established reporting mechanisms.
(b) Promptly report serious adverse events requiring hospitalization, death, or medical or surgical intervention to the appropriate regulatory agency.

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.

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

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.

Interoperability of Medical Devices H-480.953
Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.

Medical Device “Use Before Dates” D-480.977
Our AMA will encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the "use before date" for medical devices.

Access to Medical Care D-480.991
Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945
Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.

Protecting Social Media Users by Updating FDA Guidelines D-105.995
Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.

Patient Access to Treatments Prescribed by Their Physicians H-120.988
1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

Registry of Implantable Devices H-480.986
It is the policy of the AMA: (1) to support the concept of a computerized national tracking system for long-term implanted devices that pose a significant risk of serious harm or death to patients if they malfunction or fail completely; (2) that such a system include the communication of the potential for malfunction or failures to the attending surgeon or physician and from the physician to the patient; and (3) to work with all involved parties to satisfactorily address this issue.

Latex Allergy Warning H-480.970
The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care.

Physicians and Clinical Trials D-460.979
Our AMA supports elimination of the use of restrictive covenants or clauses that interfere with scientific communication in agreements between pharmaceutical companies or manufacturers of medical instruments, equipment and devices, and physician researchers.

Availability of Professionals for Research H-460.982

(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.

Comparative Effectiveness Research H-460.909

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both

physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed, and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short-term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

FDA H-100.992

(1) Our AMA supports 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) the evidence for drug approval should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies, as appropriate; (c) expedited programs for drug approval serve the public interest as long as sponsors for drugs that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile; (d) confirmatory trials for drugs approved under accelerated approval should be planned at the time of expedited approval; (e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for conducting confirmatory trials; (f) 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; and (g) FDA should make the annual summary of drugs approved under expedited programs more readily available and consider adding information on

confirmatory clinical trials for such drugs to the drugs trials snapshot. (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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 23
(I-19)

Introduced by: Lavanya Easwaran, Molly Benoit, University of Miami Miller School of Medicine, Elaine Tran, Brown University Warren Alpert Medical School; Divy Mehra, Nova Southeastern KP College of Osteopathic Medicine

Subject: Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, In 2015, 1 million Americans were legally blind (20/200 vision or worse), 3.2 million Americans had visual impairment (20/40 vision or worse with best possible correction), and 8.2 million had vision problems due to uncorrected refractive error[1]; and

Whereas, The number of people with blindness and visual impairment is expected to double to more than 8 million by 2050[2]; and

Whereas, Another 16.4 million Americans are expected to have difficulty seeing due to correctable refractive errors (myopia or hyperopia) that can be fixed with glasses, contacts or surgery[1]; and

Whereas, The American Academy of Ophthalmology recommends that adults get a complete eye examination at age 40 and those with a history of diabetes, high blood pressure, or family history of eye disease should get a complete eye examination before the age of 40[3]; and

Whereas, The American Academy of Ophthalmologists, the American Optometric Association, and the American Diabetes Association recommend an annual dilated eye examination for all people with diabetes, since the early identification and treatment of diabetic retinopathy is cost-effective and reduces vision loss[4]; and

Whereas, Early signs of age-related eye diseases (e.g. cataract, glaucoma, diabetic retinopathy, age-related macular degeneration) can begin in midlife but do not noticeably impact vision until later[5]; and

Whereas, Vision impairment can impact individuals' ability to maintain employment and increases the difficulty of performing basic self-care activities of daily living (e.g. eating, dressing) and instrumental activities of daily living (e.g. shopping, financial management, medication management, driving)[6,7]; and

Whereas, The Centers for Disease Control and Prevention (CDC) has noted that vision health disparities disproportionately affect those in the lowest socioeconomic class and those most likely to qualify for benefits from Medicaid[8]; and

Whereas, There are no federal guidelines requiring Medicaid coverage of routine visual

screening exams in adults 21 years and older with most participating states providing vision screening coverage at 24 to 48-month intervals[9]; and

Whereas, Only thirty-three states offer optional, limited Medicaid coverage of eyeglasses and other visual aids; six states only offer these benefits to children and those with severe eye conditions (i.e. aphakia)[10]; and

Whereas, Medicaid beneficiaries find it harder to obtain an eye care appointment compared to individuals with private health insurance and were 234% more likely not to receive any glaucoma testing after initial testing[9]; and

Whereas, The estimated annual total financial burden of major adult visual disorders for taxpayers in the U.S. is $35.4 billion ($16.2 billion in direct medical costs, $11.1 billion in other direct costs, and $8 billion in productivity losses)[11]; and

Whereas, Fifty-five percent of patients in need of prescription lenses were unable to obtain them and the most frequent cause was lack of financial ability[12]; and

Whereas, Several proposed federal insurance reform bills, including the S. 1129 Medicare for All Act of 2019, have highlighted the suboptimal coverage of vision screenings under current Medicare and Medicaid plans[13]; and

Whereas, Routine eye examinations in asymptomatic patients led to the discovery of at least one significant change in eye health for 58% of patients and 16% of patients have a new critical diagnoses[14]; and

Whereas, The USPSTF has released no statements or recommendations regarding screening for asymptomatic adult (18-65 years of age) populations while the American Academy of Ophthalmology recommends baseline comprehensive eye exams beginning at age 40[3,15]; therefore be it

RESOLVED, That our AMA encourages appropriate scientific and medical research to determine the benefits of routine comprehensive eye exam and benefits of visual aids in adults eligible for Medicaid.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Encouraging Vision Screening for Schoolchildren H-425.977
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 evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate.

Eye Exams for the Elderly H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

Medical Care for Patients With Low Incomes H-165.855
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.

Encouraging Vision Screening for Schoolchildren 60.010 MSS
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)

Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes 440.25 MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 24
(I-19)

Introduced by: Michael Armaneous, Touro University Nevada College of Osteopathic Medicine; Russyan Mark Mabeza, David Geffen School of Medicine at University of California – Los Angeles; Krista Allen, Rachel Landin, Rocky Visa University College of Osteopathic Medicine

Subject: Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The American College Application Service (AMCAS) is the American Association of Medical College's (AAMC) centralized medical school application processing service and is used by most US medical schools as the primary application method for their entering class[1]; and

Whereas, The 2019 medical school application fee through AMCAS is $170 for the first application and an additional $40 for each application after[2]; and

Whereas, It is estimated that the average cost of secondary applications is $80 per application, and pre-medical applicants apply to an average of 16 medical schools per cycle[3,4]; and

Whereas, Pre-medical students without AAMC Fee Assistance Program (FAP) benefits spend at least $2,800 on application fees alone, not including travel costs for interviews[5]; and

Whereas, Spending $2,800 on application fees alone would be four times greater than the amount the median US household saves for miscellaneous fees in their budget[6]; and

Whereas, The Medical College Admission Test (MCAT), developed and administered by the AAMC, is a standardized, multiple-choice examination created to help medical school admissions offices assess students[7]; and

Whereas, The cost of MCAT registration is $315, with additional fees for late registration and changing test dates[9], not including test-prep material recommended to most students which are offered by the AAMC and other test-prep companies; and

Whereas, The University of California Berkeley Career Center estimates a total cost of approximately $7,520 total for the medical school application process as of 2014, and notes that the cost is higher for those applying to both allopathic and osteopathic programs[10]; and

Whereas, The AAMC generated over $70 million dollars in revenue by administering the MCAT and AMCAS alone in 2016[8]; and

Whereas, The Fee Assistance Program (FAP), offered by AAMC, exists to assist those who, without financial assistance, would not be able to apply to medical schools who use the AMCAS application and would not be able to afford the MCAT registration fee[9]; and

Whereas, In order to qualify for the 2019 FAP, the applicants' total family income in 2018 must be 300% or less than the 2018 national poverty level for that family size[11]; and

Whereas, In contrast to other federally funded programs, the FAP does not distinguish between independent or dependent tax statuses, and therefore, parental financial information and tax documents are required and must also fall within eligibility guidelines; This requirement is not waived based on marital status, age or tax filing status[11]; and

Whereas, An applicant having an income that meets the eligibility requirements for fee assistance themselves, are denied based on parental income[11]; and

Whereas, The Free Application for Federal Student Aid (FAFSA) provided for by the U.S. Department of Education does not require an applicant to report parental income if they file taxes as an independent[12]; and

Whereas, The Expected Family Contribution (EFC) is an index number used by the FAFSA based on family's taxed and untaxed income, assets, and benefits to generate a sliding-scale model in which a lower EFC indicates eligibility for more financial aid[13]; and

Whereas, Offering additional need-based aid to students increases the odds of obtaining their degree, thus helping to reduce inequality in higher education[14]; and

Whereas, In 2017, less than 5% of entering medical students came from the lowest quintile of family income while 51% came from the highest quintile[15]; and

Whereas, Despite several efforts to make medical education attainable to low-income students, the cost of attending medical school continues to rise, making it even more difficult for low-income students and families to afford in the future[16]; therefore be it

RESOLVED, That our AMA advocate to eliminate reporting parental income as an eligibility requirement for Fee Assistance Program (FAP) applicants that are filing taxes as an independent; and be it further

RESOLVED, That our AMA work with the American Association of Medical Colleges' (AAMC) in conducting a study of the financial impact of the current Fee Assistance Program (FAP) policy to medical school applicants; and be it further

RESOLVED, That our AMA work with the American Association of Medical Colleges' (AAMC) in developing a sliding-scale model for the Fee Assistance Program (FAP) based on a financial need index.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
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.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:
(a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools;(c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.92

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.

Cost and Financing of Medical Education and Availability of First Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

MSS Financial Burden of Application to Medical School and Residency 305.083MSS

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.

Availability of Medical Education 295.005MSS
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.

Medical School Admission Policies 305.004MSS
AMA-MSS will ask the AMA to:
(1) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education;
(2) 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 of the sources of financial aid available; and
(3) 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.

Financial Aid Dependency Status of Medical Students 305.072MSS
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

Solutions to Tackling the Increasing Cost of Medical Education 305.060MSS
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

Increasing Availability and Access to Financial Aid 305.088MSS
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-MSS 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. AMA-MSS Digest of Policy Actions/ 99
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 25
(I-19)

Introduced by: Region 3; Region 4; Annie Yao, Jinhong Dong, Ryan Englander, University of Connecticut

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime rate taking place on rental properties by penalizing property owners if repeated incidents of nuisance activity occur over a set period of time (typically, 12 months)[1]; and

Whereas, CNOs are part of a phenomenon called "third-party policing," through which cities require private citizens – in this case, property owners – to address criminal or otherwise undesirable behaviors[1]; and

Whereas, Punishments for violating CNO's may range from warning letters and fines to evictions and building closures, and often involve a "nuisance point system" where a certain number of accumulated points will result in eviction and other actions[1]; and

Whereas, What qualifies as nuisance activity can vary widely between municipalities, though commonly defined as the amount of contact with emergency services, first responders, and police, for criminal behavior that occurs on or near the property, or "alleged nuisance conduct" (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and others)[2]; and

Whereas, CNO's have been enacted by an estimated 2,000 municipalities across 44 states as of 2014 [3]; and

Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the source, of the nuisance activity[3,17]; and

Whereas, CNOs punish tenants who require police and emergency medical assistance by making eviction a consequence of police responses to their homes[1]; and

Whereas, The reason for calling the police is not taken into account by most CNOs, so people who experience mental health crises may be deemed perpetrators of nuisance activity for seeking emergency medical assistance at a frequency beyond the threshold established in the CNO and may be threatened with eviction by their landlords[1]; and

Whereas, Cities have fined group homes (organizations that provide community-based residences for people with disabilities) after staff sought police or emergency services assistance responding to their residents' medical emergencies[15]; and

Whereas, Health crises that can count as a CNO violation include drug overdoses: public records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are related to a person experiencing a drug overdose, many of which explicitly include violations of criminal drug abuse laws as nuisance[15]; and

Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as litter, an un-mowed lawn, or an "unsightly" yard, which can be applied against residents whose physical, mental, or health-related disabilities prevent them from meeting their municipality's maintenance standards[1]; and

Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as unconstitutional under the First Amendment, the reasoning being that it deterred tenants from seeking police assistance, and discouraged people, including domestic violence victims, from reaching out for help[4]; and

Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that chronic nuisance ordinances disproportionately impact people of color[2]; and

Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many nuisance enforcement actions in the quarter of the city with the highest concentration of people of color as it did in the quarter with the lowest concentration of people of color[2]; and

Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois revealed that properties in predominantly black neighborhoods were more than twice as likely to be cited under the city's nuisance ordinance as white neighborhoods[5]; and

Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly black neighborhoods were over two and a half times as likely to receive a nuisance citation as properties in predominantly white neighborhoods, even when the neighborhoods made similar numbers of calls[6]; and

Whereas, Women with disabilities have a 40% greater chance of experiencing domestic violence than women without disabilities[8]; and

Whereas, There are an estimated 1.3 million women who are the victims of assault by an intimate partner annually, and women have a 25% lifetime risk of intimate partner violence[7]; and

Whereas, Congress acknowledges that "women and families across the country are being discriminated against, denied access to, and even evicted from public and subsidized housing because of their status as victims of domestic violence" [7]; and

Whereas, Domestic violence advocates' efforts in the past decades have been focused on educating law enforcement on how to approach and aid victims in escaping the cycle of domestic violence while maintaining their housing[3]; and

Whereas, This initiative is directly being threatened by CNOs, as calls about domestic disturbances can result in the eviction of everyone in the household[3,10-13]; and

Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by residents experiencing domestic violence[9]; and

Whereas, Even in cases where exceptions exist, calls placed by survivors of domestic violence are regularly miscategorized and the tenants are punished under the CNO regardless[9]; and

Whereas, Such punishment of domestic violence-related calls for police and medical services discourages victims of domestic violence from seeking help in future assaults[10]; and

Whereas, The use of CNOs may contribute to the "double victimization" of domestic violence victims, who may be evicted because of allegations of disturbing other tenants or property damage caused by their abusers, and thus are more likely to hide the abuse rather than seek help like emergency services[11]; and

Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing nuisance activity is limited[6,9,12]; and

Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such behavior[12]; and

Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety, and even suicide[14,18]; and

Whereas, Individuals who lost legal rights to their housing and whose landlords applied for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to individuals who had not experienced eviction[16]; and

Whereas, individuals who are homeless or facing housing instability are more likely to report alcohol or drug dependency than those in stable housing conditions[19]; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred[13]; therefore be it

RESOLVED, That our AMA advocate for legislation, regulations, or changes in procedure to amend chronic nuisance ordinances so they ensure that calls to police and emergency services for assistance, or to report crime or unsafe conditions, are never counted towards nuisance designations; and be it further

RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of situations in which chronic nuisance ordinances are disproportionately enforced in some communities over others.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Eradicating Homelessness 440.048MSS
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

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States 440.060MSS
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)

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data 440.064MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 26
(I-19)

Introduced by: Charles Tsouvalas, Firas Askar, Fiona Clowney, Amanda Manly, Aileen Haque, Olivia Rizzo, Aashna Sahi, Aaron Sherwood, Amitosh Singh, Wayne State University School of Medicine

Subject: Urban Forestry as Public Health Infrastructure

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, There is an 8% increase in lung cancer mortality, a 9% increase in cardiopulmonary mortality and a 14% increase in all-cause mortality for each 10 pg/md increase in exposure of particulate matter less than 2.5 microns ($PM_{2.5}$)[1-3]; and

Whereas, The deleterious health consequences of these particles led to their regulation by the U.S. Environmental Protection Agency (EPA) over the last few decades, resulting in a reduction of 22,000-60,000 premature mortalities between 2000-2007 in the U.S.[4]; and

Whereas, The American Medical Association (AMA) supports stricter National Ambient Air Quality Standards (NAAQS) than those currently regulated for $PM_{2.5}$ (H-135.946, D-135.983)[5]; and

Whereas, The concentration of nitrogen dioxide (NO_2) is strongly correlated with other toxic pollutants, is often used as a surrogate for the pollutant mixture as a whole and is a major fraction of the ambient $PM_{2.5}$ air mass[6]; and

Whereas, The AMA believes that attaining the NAAQS standards for nitrogen oxides is necessary for the long-term benefit of the public's health, and endorses a more effective hazardous pollutant program to reduce serious health hazards posed by airborne toxic pollutants (H-135.991); and

Whereas, Urban forestry is the planning and management of trees, forests and related vegetation within communities to create or add value[7]; and

Whereas, Trees, and by extension, urban forestry, directly affect particulate matter in the atmosphere by removing particles such as $PM_{2.5}$[8]; and

Whereas, A 2013 study documented urban forestry-related reductions of PM2.5 in ten major U.S. cities, which was associated with an average annual reduction of 7,270 cases of acute respiratory symptoms and 4,650 cases of asthma exacerbation across the ten cities studied[9]; and

Whereas, Air pollution removal by urban forestry prevented more than 850 premature mortalities and 670,000 incidences of acute respiratory symptoms[10]; and

Whereas, The overall prevalence of asthma in the United States has increased from 7.3% to 8% of the entire US population from 2001 to 2017, including 6 million children under the age of 18[11]; and

Whereas, An increase of 343 trees/km^2 was associated with a lower prevalence of childhood asthma, even when controlling for potential confounders such as proximity to pollution sources, sociodemographic characteristics and population density[12]; and

Whereas, The nationwide loss of 100 million trees from 1990-2007 by the invasive emerald ash borer pest was associated with an additional 6,113 deaths related to respiratory system illnesses and 15,080 cardiovascular-related deaths[13,14]; and

Whereas, From 2009-2014 tree coverage in U.S. urban and community areas declined at a rate of 175,000 acres per year, or approximately 36 million trees per year[15]; and

Whereas, 44 states from 2009-2014 were found to have a decline in urban-area tree coverage, with 23 states having a statistically significant decrease[15]; and

Whereas, Living near urban forestry has demonstrated additional public health benefits beyond the well-documented cardiopulmonary benefits including enhanced immune responses, increases in intracellular anti-cancer proteins, and increases in weekly physical activity[16,17]; and

Whereas, Urban forests have demonstrated additional biophysical benefits beyond improved air quality including reduced building energy, reduced storm water runoff, reduced soil erosion, carbon sequestration, avoided carbon emissions, and reducing the “urban heat island” effect[18-22]; and

Whereas, Urban forests consistently demonstrate to be a cost-effective means by which to provide both public health and biophysical benefits[17-22]; and

Whereas, Surveys of U.S. urban residents have consistently found that residents overall have a positive perception of urban forestry, believe government plays a key role in funding and managing urban forestry, and that residents are more likely to value urban forestry if they understand the associated social, biophysical and public health benefits [23-27]; and

Whereas, Cities such as New York City and Los Angeles each have a decade-old million-tree reforestation initiative citing the documented public health and biophysical health benefits[28-29]; and

Whereas, Urban forestry is managed at the state level by the various state Department of Natural Resources, which partner with the federal U.S. Forest Service’s Urban and Community Forestry Division, departments that are unrelated to public health[30-31]; and

Whereas, The benefits of trees in urban forestry initiatives are often viewed through the lens of biophysical benefits without providing adequate weight to the public health benefits, which underestimates the total value of trees and leads to inefficiently designed urban forestry programs[32]; and

Whereas, Experts argue that associating public health outcomes with urban forestry will prioritize urban forestry-related programs for resource allocation and improve their efficiency, as exemplified in urban forestry projects carried out in Toronto[33-35]; therefore be it

RESOLVED, That our AMA-MSS recognizes the positive impact of urban forestry on air quality and related respiratory conditions, and the need for state and national policy to expand funding for urban tree-planting and maintenance programs; and be it further

RESOLVED, That our AMA-MSS acknowledges urban forestry as public health infrastructure in recognition of the public health and biophysical benefits of urban forestry-related programs.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
CSAPH Rep. 3, I-08; Reaffirmation A-14

Green Initiatives and the Health Care Community H-135.939
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. Reaffirmed in lieu of: Res. 504, A-16

Protective NAAQS Standard for Fine Particulate Matter (PM 2.5) H-135.946
Our AMA supports more stringent air quality standards for particulate matter than those proposed by the EPA Administrator. This position is supported by several medical specialty societies. Modified: CSAPH Rep. 01, A-19

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees. Reaffirmed: CSAPH Rep. 1, A-10

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and

the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. Reaffirmed: I-16

Protective NAAQS Standard for Fine Particulate Matter (PM 2.5) D-135.983
Our American Medical Association will: (1) submit comments during the public comment period on the National Ambient Air Quality Standards (NAAQS) supporting a tightening of the NAAQS for fine particulate matter (PM 2.5); and (2) specifically request a NAAQS that provides improved protection for our patients which includes:
- 12 Âµg/m3 for the average annual standard
- 25 Âµg/m3 for the 24-hour standard
- 99th percentile used for compliance determination
Modified: CSAPH Rep. 01, A-19

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health. 2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA’s Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. Reaffirmed: A-14

Public Health Hazards Associated with Landscaping Services D-135.986
Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect, grub control, tree, bush care, debris removal, fence, driveway, rock garden,

stone path construction requiring use of saws, and a full spectrum of motorized equipment). Reaffirmed: A-16

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA. (2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources. (3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants. (4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved. (5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. Reaffirmation A-14

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. Reaffirmed: BOT Rep. 29, A-19

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants. Reaffirmed: CSAPH Rep. 01, A-17

Environmental Protection 135.002 MSS
AMA-MSS will ask the AMA to support strong federal enforcement of environmental protection regulations. Reaffirmed: MSS GC Rep D, I-15

Toward Environmental Responsibility 135.012MSS
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. Modified: MSS GC Report A, I-16

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 27
(I-19)

Introduced by: Region 1; Region 5; Arjun Kumar, New York Institute of Technology; Tiffany Wong, New York Medical College

Subject: Ethical Considerations of Big Data Health Research

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, "big data" refers to large sets of information often collected from sources including online platforms, social media, electronic health records (EHRs), financial records, and self-tracked health and fitness parameters from mobile applications, which can be analyzed by researchers using computational techniques[1]; and

Whereas, big data health research has become increasingly prevalent in the health care sector, allowing researchers to gain insight into genomics, population health, clinical trends, and disease outcomes, as a way to construct informed public health policies, quality care improvement initiatives, and further drug development technologies[1,2,3]; and

Whereas, despite the benefits of using large datasets for health research, this research has been criticized for not obtaining informed consent, and posing significant ethical risks to consumers and patients with regards to privacy, discrimination, and more[4,5,6]; and

Whereas, researchers can aggregate data from EHRs, social media, mobile health applications, and genetic testing, creating "health profiles" that could potentially be sold to private companies or government agencies (including law enforcement) without consumer knowledge, posing ethical concerns regarding downstream use of this data[5,6,7,8]; and

Whereas, there have been multiple instances of companies using identifiable public and private datasets to collect health data about individuals, connect this data to researchers, and sell this data to third parties, without proper measures in place for awareness and consent[4,9,10]; and

Whereas, the company PatientsLikeMe, for example, uses social media platforms to collect people's health data, publish their data publicly, and sell their data to pharmaceutical and social media companies like Facebook, without explicit consumer knowledge[10]; and

Whereas, the Common Rule, established in 1981, mandates that federally funded projects involving human subjects undergo review by Institutional Review Boards (IRBs), to protect subjects from psychological, physiological, and informational harm[11]; and

Whereas, the Health Information Portability and Accountability Act (HIPAA) only provides protections to identifiable health information held or transmitted by health plans, providers, and

business associates, and doesn't mandate ethics review for big data collection and subsequent use unless it falls under the purview of the Common Rule[12,13]; and

Whereas, in January 2017, the Department of Homeland Security revised the Common Rule, excluding publicly available identifiable datasets, and completely or mostly exempting secondary research of identifiable information, from IRB review[14,15]; and

Whereas, the de-identification process of patient and genetic records to distance data from real identities is no longer satisfactory, due to the ease of combining and linking various online sources that can lead to re-identification, highlighting the need to create ethical guidelines on big data health research, even for de-identified data[7,10]; and

Whereas, the Federal Trade Commission has determined that companies that collect, utilize, and/or sell people's "big data" only have the legal obligation to notify if the person's file caused a denial of coverage or other adverse action[16]; and

Whereas, in the absence of ethical guidelines, Ethics Review Committees (ERCs) are currently struggling to come up with a methodological approach for assessing research projects involving big data, especially when it comes to reviewing public data acquired from online platforms such as Twitter or Facebook[1]; and

Whereas, in May 2018, the European Union General Data Protection Regulation (EU GDPR) went into effect to address this issue, creating a European Data Protection Board to enforce data privacy concerns, requiring that patients give explicit consent for use of their health data, and prohibiting discriminatory profiling[17,18]; and

Whereas, there have been additional international efforts to encourage researchers to ethically adhere to "the right to science", which includes addressing issues such as privacy protection, accountability, and compliance in big data health research[19]; and

Whereas, while current AMA policy (3.1.1, 3.2.4, 7.2.1) recognizes a patient's right to privacy and addresses ethical concerns regarding the privacy of EHRs, including third-party access to EHRs, it does not specifically cover big data health research that originates from social media, mobile applications, and other sources; and

Whereas, the acknowledgement of the benefits of big data in research, public policy, quality care improvement, and more, should not be presumed more important than patients' and consumers' right to privacy; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to develop ethical research guidelines for the use of health information collected from public and/or private data sets that originate from social media, online platforms, and devices, including but not limited to personal cell phones and wearable gadgets; and be it further

RESOLVED, That our AMA support the creation and enforcement of ethical guidelines by appropriate federal agencies pertaining to the collection and downstream use of health research involving large data sets.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Research Handling of De-Identified Patient Information D-315.975
Our AMA will study the handling of de-identified patient information and report findings and recommendations back to the AMA House of Delegates.

3.1.1 Privacy in Health Care
Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).
Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

3.2.4 Access to Medical Records by Data Collection Companies
Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.
Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.
Physicians who propose to permit third-party access to specific patient information for commercial purposes should:

(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:

(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.

(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

7.1.3 Study Design & Sampling

To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design.

Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable.

Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:

(a) Is consistent with the goals and fundamental values of the medical profession.
(b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.
(c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).
(d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.
(e) Provides mechanisms to safeguard confidentiality.
(f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.
(g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participant's legally authorized representative, in keeping with ethics guidance.
(h) Has been reviewed and approved by appropriate oversight bodies.

7.2.1 Principles for Disseminating Research Results

Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques.

To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should:

(a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain.
(b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis.
(c) Maintain a commitment to peer review.
(d) Disclose sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance.
(e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has been obtained from research participants (or participants' legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information.
In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse.

Proposing Consent for De-Identified Patient Information 140.035MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 28
(I-19)

Introduced by: Region 1; Region 3; Region 4; Region 5; Region 7

Subject: Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Rape and/or sexual assault is common in the United States, with between 135,755 and 393,980 rapes and/or sexual assaults committed in 2017 alone[1,2]; and

Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence, including unwanted sexual contact of any kind, in their lifetimes[3]; and

Whereas, Rape and sexual assault are associated with a wide range of medical and psychological sequelae, including direct physical trauma, PTSD, depression, social phobias, mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and suicide attempts[4-14]; and

Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are committed by serial offenders[15-19]; and

Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the incidence of future sexual violence committed by these serial offenders[17-23]; and

Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store evidence from a victim of sexual assault during a sexual assault forensic examination[24], are extremely useful in the identification and prosecution of perpetrators of violent sexual crime and are positively associated with successful prosecutions[17,19,22,23,25-27]; and

Whereas, Even when suspects cannot be immediately identified on the basis of the DNA signature derived from a SAEK, law enforcement officials can upload the DNA profile to the Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in the later identification of the perpetrator[28]; and

Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law enforcement evidence warehouses ("backlogged"), with estimates placing the number of backlogged kits as high as 200,000 nationwide[19,29]; and

Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies and procedures, including federal guidelines, inadequate training of law enforcement officers, outdated laboratory policies and lack of resources, such as funding[30]; and

Whereas, The United States Department of Justice's Violence Against Women Act of 1994 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical services to sexual assault survivors contingent on those programs incurring the full cost of forensic medical exams through the offices of State Attorney's General[31-33]; and

Whereas, Standardized insurance billing procedures that include copays and other cost-sharing payments cause victims of sexual assault to be billed for part of the cost of testing forensic evidence, notwithstanding federal mandates like VAWA[34,35]; and

Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing backlogged SAEKs, has resulted in the disbursement of $43 million and the testing of 50,500 kits[40-42]; and

Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their possession have been extraordinarily successful in solving previously unsolved rapes and sexual assaults[17,19,21,22,36-40]; and

Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and incarceration of serial offenders that would have prevented later assaults[17,19-22,36-38]; and

Whereas, The $9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new forensic examinations in addition to comprehensive coverage of investigations on backlogged kits with a net estimated savings of $38.7 million, highlighting the cost effectiveness of testing SAEKs[41,42]; and

Whereas, Existing AMA Policy H-80.999 outlines the rights of sexual assault victims but neither explicitly describes the right to have collected medical forensic evidence be tested in a timely manner nor addresses the backlog of untested sexual assault evidence kits; therefore be it

RESOLVED, Our AMA will advocate at the state and federal level for (a) the immediate processing of all "backlogged" and new sexual assault examination kits; and (b) additional federal funding to facilitate the immediate testing of backlogged sexual assault evidence kits.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will 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.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports 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; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.
Res. 402, A-16; Appended: Res. 424, A-18

HIV, Sexual Assault and Violence H-20.900

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, 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; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMA Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by **victims**' own actions.

(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Increasing Patient Access to Sexual Assault Nurse Examiners 360.002MSS
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.

Sexual Assault Survivors Rights 515.010MSS
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.

Medical Education about Rape Crises 295.067MSS
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.

Trauma-Informed Care Resources 515.013MSS
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 29
(I-19)

Introduced by: Region 3

Subject: Support for Mental Health Courts

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, “Mental health courts” are state and local legal mechanisms that help individuals with serious mental illness receive psychiatric treatment[1-2]; and

Whereas, Mental health courts offer treatment for mental illness as an alternative to incarceration for individuals with mental illness who commit criminal offenses[1-2]; and

Whereas, The use of mental health courts is encouraged by many national organizations, including the American Psychiatric Association, the US Substance Abuse & Mental Health Services Administration, and the US Department of Justice[3-5]; and

Whereas, Over 500 mental health courts exist across all 50 states, but not all counties and localities have mental health courts, meaning that this mechanism may be unavailable or inaccessible for individuals in these areas[4,10]; and

Whereas, The National Institute of Corrections states that mental health courts can prevent incarceration of individuals with serious mental illness, who are otherwise three times more likely to be found in jails or prisons than mental hospitals[6]; and

Whereas, Mental health courts have been found to reduce recidivism, jail time, and the severity of charges placed on individuals with serious mental illness[7-11]; and

Whereas, Existing AMA policy “supports the establishment of drug courts” for individuals with SUDs and “encourages legislators to establish drug courts at the state and local level in the United States”[12]; and

Whereas, Many mental health courts are supported by public funds, such as the US Substance Abuse and Mental Health Services Administration,[13-14] and therefore the role of organizations such as the AMA in collaborating with federal, state, and local policymakers can be important in maintaining financial support for mental health courts; and

Whereas, While mental health courts can be considered a broad category, they may exist under many different names, with each focused on different types of mental illness, including “mental health courts” (often for mental illnesses that are not substance use disorders), “drug courts” (for substance use disorders), and “sober courts” (for alcohol use disorder and sometimes certain

other substance use disorders),[15] and AMA policy should be inclusive of these different types; therefore be it

RESOLVED, That our AMA amend policy H-100.955 by insertion and deletion as follows, in order to be more inclusive of the various types of mental health courts that exist:

> **Support for Drug Courts H-100.955**
> Our AMA~~: (1)~~ supports the ~~establishment~~ use of ~~drug~~ mental health courts, including drug courts and sober courts, as an effective method of intervention for individuals with mental illness and substance use disorders ~~addictive disease~~ who are convicted of nonviolent crimes~~; and (2) encourages legislators to establish drug courts~~ at the state and local level in the United States.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and (2) encourages legislators to establish drug courts at the state and local level in the United States. Res 201, A-12

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services. Res 116, A-12; Reaff: A-15

Prevention of Impaired Driving H-30.936
Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or

encouraged among the family members actively involved in the offender's life; CCB/CLRPD Rep 3, A-14

E-9.7.2 Court-Initiated Medical Treatments in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician’s diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given. AMA Principles of Medical Ethics: I, III; Issued: 2016; Mod: 2017.

E 2.1.2 Decisions for Adults Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient’s decision-making capacity. Even when a medical condition or disorder impairs a patient’s decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

(a) Identify an appropriate surrogate to make decisions on the patient’s behalf:

(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or

(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.

(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
    (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
    (ii) the patient's views about life and how it should be lived;
    (iii) how the patient constructed his or her life story; and
    (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
    (i) the pain and suffering associated with the intervention;
    (ii) the degree of and potential for benefit;
    (iii) impairments that may result from the intervention;
    (iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
    (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
    (ii) ongoing disagreement about a treatment decision cannot be resolved; or
    (iii) the physician judges that the surrogate's decision:
        a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
        b. could not reasonably be judged to be in the patient's best interest; or
        c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics I, III, VIII; Issued: 2016; Mod: 2017

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 30
(I-19)

Introduced by: Region 2; Region 5; Student National Medical Association; Amier Haidar, McGovern Medical School

Subject: Racism as a Public Health Threat

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Underrepresented or marginalized racial and ethnic populations in the United States have shorter lifespans, greater physical and mental illness burden, earlier onset and more aggressive progression of disease, higher maternal and infant mortality, and less access to healthcare services [1-11]; and

Whereas, Systemic racism is defined as a structural and legalized system that results in differential access to goods and services, including health services, while cultural racism refers to negative and harmful racial stereotypes portrayed in culturally shared media and experiences, and interpersonal racism is implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices[5,9,12,13]; and

Whereas, Systemic racism results in segregation of marginalized, racialized groups to less financially supported neighborhoods, schools, and jobs, lower salary for the same work, lower rates of promotion despite similar performance and higher rates of incarceration and police violence, all of which contribute to health inequities and have been independently associated with worse health outcomes[5,9,13-23]; and

Whereas, Interpersonal racism has been independently associated with chronic pain, poorer sleep, lower likelihood of accessing preventive screenings or prenatal care, psychosocial distress, greater likelihood of alcohol use and smoking, and lower overall health[5,24-26,28-31]; and

Whereas, In healthcare, systemic and cultural racism result in less access to care for minority groups and in different groups routinely receiving different treatment for the same complaints[9-10,13,32-34] ; and

Whereas, When interpersonal racism is committed by healthcare workers, which occurs frequently, it undermines the physician-patient relationship, harms patients' trust in the healthcare field as a whole, and makes patients less likely to seek needed care[9,12,26,27,33-39]; and

Whereas, Experiencing perceived racial discrimination induces a chronic stress response causing heritable, intergenerational epigenetic changes, compounding disparities in health outcomes and chronic disease incidence that exist even when controlling for other socioecologic factors[3,40-45]; and

Whereas, Rates of reported hate-based crimes and public expressions of discrimination against racial and ethnic minorities have increased in recent years[30,46-53]; and

Whereas, The role of racism in creating and perpetuating health disparities is frequently overlooked in research and healthcare literature and policy[5,13]; and

Whereas, Though AMA policies emphasize the need to eliminate racial and ethnic disparities in health (H-350.974, D-350.984, D-350.995, H-350.953, D-350.991, H-440.869, H-65.963) and calls upon physicians to actively work to prevent violence of all kinds (H-515.964, H-515.971, H-515.979, H-145.970), AMA policy currently does not recognize the role of racism in perpetuating health disparities and inciting violence against minority groups; therefore, be it

RESOLVED, Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious public health threat and a barrier to appropriate medical care; and be it further

RESOLVED, Our AMA will develop a set of current best practices for recognizing, addressing, and mitigating the effects of racism on patients and populations; and be it further

RESOLVED, Our AMA shall encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs that engender greater understanding of the causes, influences, and effects of systemic, cultural, and interpersonal racism and how to prevent and ameliorate the health effects of racism; and be it further

RESOLVED, That our AMA:
(A) encourages the development of innovative legislation to combat racism and its effects on health;
(B) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Violence Activities H-515.964
Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes;
(2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and
(3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine.

Public Health Policy Approach for Preventing Violence in America H-515.971
The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts.

Violence as a Public Health Issue H-515.979
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.

Nondiscrimination in Responding to Terrorism H-65.978

Our AMA: (1) affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism.

8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Racial and Ethnic Disparities in Health Care H-350.974
1. 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.

2. The AMA emphasizes three approaches that it believes should be given high priority:
A. 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.
B. 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.
C. 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

3. 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.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Reducing Racial and Ethnic Disparities in Health Care D-350.995
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.

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (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.

Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; (3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and (4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this

relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum: That our AMA-MSS recognize 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; (2) That our AMA-MSS 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)

295.193MSS Implicit Bias and Its Effects on Healthcare and Its Incorporation into Undergraduate Medical Education: That our AMA-MSS recognizes the existence of implicit bias among health care clinicians; and be it further (2) That our AMA-MSS recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and be it further (3) That our AMA-MSS support 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 31
(I-19)

Introduced by: Region 5; Ellena Popova, Perelman School of Medicine at the University of Pennsylvania

Subject: Conforming Sex and Gender Designation on Government IDs and Other Documents

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

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

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

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

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

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

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

Whereas, Government issued IDs include, but are not limited to, birth certificates, passports, driver's licenses, and Department of Defense ID cards; and

Whereas, Nine states plus New York City and the District of Columbia already issue updated sex designations on birth certificates and/or driver's licenses without requiring documentation from a medical provider[3-13]; and

Whereas, Nine states plus New York City and the District of Columbia also offer birth certificates and/or driver's licenses with a gender-neutral option[3-5,9-11,13-17]; and

Whereas, MSS policy 65.019MSS on sex designation on government issued identification, created in 2013, contradicts AMA policy H-65.967, amended in 2019; and

Whereas, The AMA amended policy H-65.967 supports every individual's right to determine gender designation on government issued identification, policy that allows change of sex designation on government issued IDs without medical professional verification, policy that includes a non-binary gender option in addition to "male" and "female" gender options, and that sex designation on government issued ID does not limit access to medical care; therefore be it

RESOLVED, That our AMA-MSS will amend policy 65.019MSS by addition and deletion to be congruent with AMA H-65.967 as follows:

~~Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients~~ Conforming Sex and Gender Designation on Government IDs and Other Documents, 65.019MSS

Our 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)~~

(1) every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification; and (2) policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional; and (3) policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female"; and (4) efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.

Fiscal Note: TBD

Date Received: 09/20/2019

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4. California Gender Recognition Act, SB 179, https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201720180SB179 .
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6. Idaho Division off Public Health Instructions to Change the Indicator of Sex on an Idaho Birth Certificate to Reflect Gender Identity, https://healthandwelfare.idaho.gov/Portals/0/Health/Vital%20Records/GenderChangePacket_4-18.pdf.
7. MA Gender Designation Change Form, https://www.mass.gov/files/documents/2018/03/22/LIC108%20-%20Massachusetts%20Gender%20Designation%20Change%20Form_0.pdf.
8. Montana Rule 37.8.311, Adoptions, Name Changes, and Gender Changes, http://www.mtrules.org/gateway/RuleNo.asp?RN=37.8.311
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12. Oregon Health Authority House Bill 2673 Information Sheet, https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/CHANGEVITALRECORDS/Documents/OHA-2673.pdf; Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.
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14. Colorado Change of Sex Designation, https://www.colorado.gov/pacific/sites/default/files/DR2083.pdf.
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16. MN Driver and Vehicle Services Self-Designated Descriptors, https://dps.mn.gov/divisions/dvs/Pages/self-designated-descriptors.aspx
17. Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.

RELEVANT AMA AND AMA-MSS POLICY

Conforming Sex and Gender Designation on Government IDs and Other Documents H-65.967

1. Our AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.

Medical Spectrum of Gender D-295.312
Our AMA will work with appropriate medical organizations and community-based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity.

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961
Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

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 (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT 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 LGBT patients; (iii) encouraging the development of educational programs in LGBT 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 LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT 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.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT 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 LGBT people.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation,

gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS
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.

Reducing Suicide Risk among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth through Collaboration with Allied Organizations 65.015MSS
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.

Protection of Transgender Individuals' Right to Use Public Facilities in Accordance With Their Gender Identity 65.022MSS
AMA-MSS supports transgender individuals' right to use public facilities in accordance with their gender identity to mitigate harms.

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 295.190MSS
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.

Improving Primary Care Residency Training to Advance Health Care for Gay, Lesbian, Bisexual, and Transgender Patients 310.041MSS
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 32
(I-19)

Introduced by: Bryana Baginski, Dory Askins, University of South Carolina School of Medicine – Greenville; Natasha Venugopal, Augusta University

Subject: Amending H-160.963, to Include Supporting Increased Access and Reimbursement for Community-Based Recovery Services

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, An estimated 20.7 million people over the age of 12 years old suffer from substance use disorder, however, only 19% of those who needed it, received treatment[1]; and

Whereas, Historically, substance use disorder has been addressed through intense professional services during acute episodes, with high relapse rates[2]; and

Whereas, In those with substance use disorder that received a referral from healthcare providers, as is used in current practice, only 32% completed a treatment plan at two-month follow-up[3]; and

Whereas, The use of peer and community-based recovery services has increased retention in treatment programs, increased abstinence, resulted in more primary care visits, and fewer ED/hospital admissions[2]; and

Whereas, Community based programs that focus on substance abuse have a better 12-month outcome compared to rehabilitation programs[4]; and

Whereas, Community based recovery have a positive impact, particularly in populations that are socially disadvantaged[5]; and

Whereas, Community based recovery programs are not available to all populations in all areas of the country, with a contributing factor to the discrepancies across the country being a variation in Medicaid reimbursement for community health services that has resulted in a lack of financial incentive that stunt the growth of community-based recovery services[6,7]; and

Whereas, Community based recovery services that provide treatment for substance use disorders need a stable source of funding to achieve their full impact regarding accessibility and quality of care[8,9]; and

Whereas, Our AMA recognizes substance use disorder as a major public health problem and supports novel and collaborative approaches to its treatment, including community-based treatment centers (H-95.975, D-95.981, H-160.963); therefore be it

RESOLVED, That AMA policy H-160.963, Community-Based Treatment Centers be amended by addition as follows:

Community-Based Treatment Centers H-160.963
Our AMA: (1) supports the use of community-based treatment centers for substance abuse, emotional disorders and developmental disabilities; (2) encourage increased access to recovery services through the development of treatment centers in socially disadvantaged communities; (3) supports increased access to federal funding for the research and development of community-based treatment programs, particularly in areas where there are strong social barriers to healthcare; (4) will advocate for Medicaid reimbursement of services provided through community-based treatment programs.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening,

diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

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

1. Our AMA: a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth; b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics; c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends; d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to: a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach; (2) declares substance use disorders are a public health priority; (3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction; (4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and (5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Community-Based Treatment Centers H-160.963

Our AMA supports the use of community-based treatment centers for substance abuse, emotional disorders and developmental disabilities.

Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services H-345.980

Our AMA advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and substance use disorder services to our citizens.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 33
(I-19)

Introduced by: Matthew Christensen, Courtney Harris, Alvin Singh, Chicago Medical School at Rosalind Franklin University; Jazmyn Shaw, University of Mississippi Medical Center School of Medicine; Corey McNeilly, University of Texas Health – San Antonio; Samuel Southgate, University of Connecticut School of Medicine; Alex Cook, University of North Carolina School of Medicine; Daniel Jourdain, Brody School of Medicine at East Carolina University; Elizabeth Kleiner, Des Moines University; Ashley Tarchione, University of Nevada Reno School of Medicine; Jacob Freudenberger, University of North Texas Health Science Center – Texas College of Osteopathic Medicine

Subject: Supporting the InCUS Report Recommendations to Explore Further Research into Possible Changes to the USMLE Step 1 Scoring System

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Association of American Medical Colleges (AAMC), American Medical Association (AMA), the Educational Commission for Foreign Medical Graduates (ECFMG), the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) held the Invitational Conference on USMLE Scoring (InCUS) in March 2019 to explore changes to United States Medical Licensing Examination (USMLE) scoring and the broader transition from undergraduate medical education (UME) to graduate medical education (GME)[1]; and

Whereas, The AAMC, AMA, ECFMG, FSMB, and NBME published a summative report in March 2019 outlining key takeaways from InCUS with formal recommendations for future discussion and review of the USMLE scoring system[1]; and

Whereas, USMLE was principally designed to maximize precision at the pass/fail point, and not intended to be interpreted as an academic achievement exam[1,2,3]; and

Whereas, USMLE scores do not predict ultimate clinical performance in an emergency medicine residency program, are not correlated to the likelihood of a surgical resident obtaining board certification, and are less reliably correlated to the performance evaluation scores of Internal Medicine residents than other standardized measures of evaluation including USMLE Step 2 CK[4-6]; and

Whereas, There is no statistical correlation between USMLE scores and reliable measures of clinical skill acquisition including history taking, medical decision making, or communication with the patient and patient care team, nor the performance of various technical skills including central venous catheter insertion, thoracentesis, temporary hemodialysis catheter insertion, or advanced cardiac life support outcomes[3]; and

Whereas, 94% of residency program directors in 2018 identified USMLE Step 1 scores as an above average-importance criterion for selecting candidates to interview, demonstrating more consensus than any other identified criterion[7]; and

Whereas, Studying for “high stakes” examinations such as USMLE Step 1 is considered an exceptional life stressor with significant adverse effects on medical student well-being[8,9,10]; and

Whereas, Multi-institutional studies of medical students graded on a pass/fail evaluation system during the preclinical years have demonstrated lower levels of stress, emotional exhaustion, burnout, and depersonalization compared to students graded on a traditional academic grading scale with no adverse effects on objective academic performance[11,12]; and

Whereas, USMLE Step 1 examinations have shown significant scoring differences by gender and race and is identified by minority students as the largest barrier to applying to classically competitive dermatology residency programs[13,14,15]; and

Whereas, A paucity of research exists that correlates USMLE examination scores to measures of success in residency or clinical practice, raising concern among medical students regarding the wide use of USMLE scores as an unvalidated screening tool during the residency application process[1,3]; and

Whereas, Otherwise qualified students may be excluded from their preferred subspecialties and residency programs or from matching completely, based on arbitrary filters involving a number with unproven predictive accuracy, nullifying years of study, research, leadership, and service[16]; and

Whereas, The USMLE is currently the singular standardized assessment tool spanning the UME-to-GME transition, emphasizing the importance of either validating it as an unbiased and clinically relevant scoring system or reevaluating its use during resident selection[1]; and

Whereas, InCUS attendees and contributors recommend convening a cross-organizational, multi-stakeholder panel to analyze systemic challenges in the UME-to-GME transition that may include but is not limited to changing the USMLE scoring system[1];

Whereas, Voicing support for the recommendations outlined in the InCUS Report is a natural next step and can be considered the first true action following adoption of the revised MSS 295.188 during A-17, which states the general intention of the MSS to “work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams”; therefore be it

RESOLVED, That the AMA-MSS supports the InCUS Report recommendation for further research regarding changes in Step 1 scoring and reporting, including but not limited to pass/fail scoring, categorical/tiered scoring, and composite scoring; and be it further

RESOLVED, That the AMA-MSS supports the InCUS Report recommendation for acceleration of research on the correlation of USMLE performance to measures of residency performance and clinical practice; and be it further

RESOLVED, That the AMA-MSS supports the InCUS Report recommendation for minimization of racial demographic differences that exist in USMLE performance; and be it further

RESOLVED, That the AMA-MSS supports the InCUS Report recommendation for convening a cross-organizational panel to create solutions for challenges in the UME-GME transition.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose

that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) 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 (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18

Proposed Single Examination for Licensure H-275.962

Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17

USMLE Scores not Sole Criteria for Residency Selection H-255.980

Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications. Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Modified: Speakers Rep. 01, A-17; Reaffirmed: CME Rep. 01, A-18

Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam 295.117MSS

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)

Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage 295.188MSS

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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 34
(I-19)

Introduced by:	Region 3; Region 4; Region 5; Student National Medical Association; Faith Crittenden, University of Connecticut School of Medicine
Subject:	Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
Referred to:	MSS Reference Committee (Pauline Huynh, Chair)

Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or the right to keep hair in an uncut or untrimmed manner [1]; and

Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for cultural purposes and serves as a way to express values of a demographic group or particular society for religious, spiritual, or gender identification [2]; and

Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious association [3-6]; and

Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate against any individual based on an "... individual's race, color, religion, sex, or national origin", and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also unintentional discrimination on the enumerated proscribed ground [7]; and

Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part of medical professionalism standards tend to be euro-centric and penalize those with non-euro-centric phenotypical features and/or culture [8,9]; and

Whereas, In 2019, the State of California and New York City have passed laws to address hair discrimination within the workplace through the CROWN Act (SB 188) and the NYC Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the Basis of Hair [1,3]; and

Whereas, United States Armed Forces have repealed several bans on natural hair and cultural headwear in the workplace (Army Regulation 670-1, Section 3-2) [10]; and

Whereas, Qualitative analysis of minority resident physicians has revealed the additional challenges to embracing their racial identities in a professional setting results in less job satisfaction and more susceptibility to burnout [11]; and

Whereas, Studies show "a positive association between physician-patient racial/ethnic concordance and patients' receiving preventive care, being satisfied with their care overall..." [12]; and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982,D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our AMA recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial/ ethnic and/or religious discrimination; and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings; and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. BOT Rep. 27, A-19.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14,Reaffirmed in lieu of: Res. 001, I-16,Reaffirmation: A-17.

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for

complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. BOT Rep. ZZ, I-90,Reaffirmed by CME Rep. 9,

A-98,Reaffirmed: CME Rep. 2, I-99,Modified: BOT Rep. 11, A-07,Reaffirmed: CME Rep. 9, A-13.

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. Res. 307, A-09, Appended: Res. 955, I-17.

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances

Discrimination Against Physicians by Patients D-65.991
Our AMA will study: (1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests. Res. 018, A-18.

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Disseminating Information to Combat Ethnic Retaliation and Racism: 65.005MSS
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)

Preventing Discrimination against Patients by Medical Students: 65.018MSS
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. (MSS Res 4, I-12) (Amended AMA Res 1, A-13 Adopted [H-295.865]) (Reaffirmed: MSS GC Report A, I-16)

Eliminating Religious Discrimination from Residency Programs: 310.033MSS
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, A04) (AMA Res 308, A-05 Referred) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 35
(I-19)

Introduced by: Region 3; James Docherty, New York Institute of Technology College of Osteopathic Medicine; Matthew Christensen, Chicago Medical School

Subject: Evaluating the Use of Third-Party Resources in Medical Education

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Medical student scores on the United States Medical Licensing Examination (USMLE) Step 1 and/or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 exams are the factors most heavily cited by residency program directors when considering applicants to interview[1]; and

Whereas, Matching into certain residency specialties and to out-of-state programs is significantly associated with higher USMLE Step 1 and Step 2 Clinical Knowledge (CK) scores, and otherwise well-achieved students often abandon application plans for certain specialty areas due to concerns a Step 1 score around the mean will disqualify them from consideration[2-4]; and

Whereas, Despite concerns about using USMLE scores as a predictor of success in residency, higher USMLE scores positively correlate with performance on clinical clerkship exams and faculty evaluations, indicating that adequate preparation for USMLE exams contributes to later success in medical school[5]; and

Whereas, Due to pressures to perform well on USMLE exams, medical students have become increasingly concerned with a disconnect between board-relevant material and what is taught through traditional, institution-created content[6-9]; and,

Whereas, A wide variety of non-institutional third-party educational resources have recently emerged which offer convenient, customizable and interactive methods for studying topics emphasized on USMLE exams; These include, but are not limited to, resources such as *First Aid for the USMLE Step 1*, *Pathoma*, *SketchyMedical* and UWorld[10-14]; and

Whereas, Studies on modern education methods show that medical students prefer a variety of active learning tools that offer multiple modes of information presentation, such as those provided by modern third-party educational resources, and will often alternate between traditional lecture material and interactive online tools or question banks depending on the material being studied[15-16]; and

Whereas, In cohorts across the country, a combination of these third-party resources were utilized and viewed as essential resources by almost all surveyed medical students during self-directed USMLE exam preparation, while very few students used or recommended institution-created content[4,17-21]; and

Whereas, One study found that amongst Osteopathic medical students, who often take both the Step and COMLEX exams, the average amount spent on taking and preparing for board exams during medical school was $7,499, with $4,129 accounting for board prep materials[18]; and

Whereas, In addition to University-scheduled dedicated USMLE preparation weeks, students have begun to use and begun to recommend non-institutional third-party resources as study resources during their time in pre-clinical courses as well as while studying for clinical clerkship exams[17,19-22]; and

Whereas, The Association of American Medical Colleges 2018 Year 2 Questionnaire found that in 2018 more than a quarter (26.3%) of students reported “almost never” attending lectures (a 6 point increase from 2016) with nearly one in three students (32.7%) reporting watching online videos instead of lectures for their medical education on a daily basis (a 16.5 point increase from 2016)[23]; and

Whereas, Early self-directed study during pre-clinical courses, spaced repetition and higher utilization of *First Aid for the USMLE Step 1* and commercially available board-style question banks significantly improved Step 1 scores, even when controlling for potential confounding covariates such as age, MCAT score and GPA[17,21,24]; and

Whereas, Many schools have taken steps towards addressing the third-party educational resource trend, including eliminating lectures, purchasing popular third-party resources for students, facilitating student-led review sessions based on third-party content and integration of Step 1 question banks into preclinical organ-based modules[17,24-27]; and

Whereas, Some schools that have modified curricula to provide and integrate third-party resources into pre-clinical organ-based modules or interactive peer-led USMLE review sessions reported increased student performance on organ-based module-specific academic outcomes and Step 1, and students noted feeling financially and emotionally supported by administration and faculty[24,27]; and

Whereas, Despite established effectiveness of certain study resources, many popular newer third-party resources have not yet been studied, and educators describe lack of understanding of student motivation for usage of third-party educational resources, effects on longer-term measures of knowledge retention and unintended consequences of “teaching to the test”[4,14,17,28]; and

Whereas, The AMA has remained heavily involved in addressing the administration methods, scoring, regulation and professional impact of the USMLE Step 1 exam, but has yet to address the widespread popularity of emerging third-party exam preparation materials and the impact on medical education; therefore be it,

RESOLVED, That our AMA work with the Association of American Medical Colleges (AAMC) and other appropriate stakeholders to study the use of non-institutional, third-party educational resources in undergraduate medical education in order to determine 1) which resources are most consistently utilized by students, 2) efficacy of their utilization on USMLE Step 1 and COMLEX Level 1 exam performance and on other preclinical educational performance measures and 3) ways in which institutions may provide and/or incorporate these resources into their preclinical curricula.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should

have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

USMLE Step 1 Timing D-275.958
Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance.

The Grading Policy for Medical Licensure Examinations H-275.95
1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) 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 (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
Independent Regulation of Physician Licensing Exams D-295.939
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination

system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

USMLE Scores not Sole Criteria for Residency Selection H-255.980
Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications.

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
It is the policy of the AMA to use its representatives on key national medical education committees to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

Proposed Single Examination for Licensure H-275.962
Our AMA: (1) endorses the concept of a single examination for medical licensure;
(2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies.

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal

structure and improved faculty counseling. An appropriate number of electives or selected options should be included.
(17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by

the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

USMLE Step 1 Timing 295.182MSS

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

Future of the United States Medical Licensing Examination (USMLE) 295.188MSS
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

USMLE Exam Fee Burden 295.150MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 36
(I-19)

Introduced by: Region 2; Region 3; Region 4

Subject: Enhancing Transparency and Regulation in the Personal Care Product Industry

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The term “personal care products” is not legally defined but commonly refers to a wide variety of items including skin moisturizers, perfumes, lipsticks, nail polishes, eye and facial makeup preparations, shampoos, hair colors, toothpastes, and deodorants[1]; and

Whereas, Regulation of the personal care product industry has not been meaningfully updated since the Federal Food, Drug, and Cosmetic Act of 1938 (FD&C Act)[2]; and

Whereas, A limited number of personal care products are regulated as pharmaceuticals, including skin protectants (such as lip balms and diaper ointments), mouthwashes marketed with therapeutic claims, antiperspirants, and skin treatments for dandruff or acne[1]; and

Whereas, Personal care products outside these categories do not require approval by the Food and Drug Administration (FDA) before they go on the market, with the exception of color additives[2,3]; and

Whereas, The World Health Organization defines an endocrine disruptive chemical (EDC) as an “exogenous substance or mixture that alters function(s) of the endocrine system and consequently causes adverse health effects in an intact organism, or its progeny”[4]; and

Whereas, Many chemicals found in personal care products such as parabens, triclosan, and phthalate esters can be classified as EDCs[5,6]; and

Whereas, EDCs have been linked to infertility, disruption in reproductive hormones, breast and ovarian cancer, early puberty effects, insulin resistance, and obesity [5-17]; and

Whereas, A database compiled by the Green Science Policy Institute reveals that there are several perfluorinated and polyfluorinated chemicals that are used in a variety of cosmetics and have been found to cause liver toxicity, disruption of lipid metabolism and the immune and endocrine systems, adverse neurobehavioral effects, neonatal toxicity and death, and tumors in multiple organ systems in animal studies [5,18,19]; and

Whereas, A study evaluating self-reported cosmetic-related adverse health outcomes in the FDA’s Center for Food Safety and Applied Nutrition’s Adverse Event Reporting System (CFSAN) found that consumers attribute a significant proportion of serious health outcomes to

cosmetics, in addition to a study that showed a positive dose-response relationship between frequency of maternal cosmetics use during pregnancy and small gestational age [20,11]; and

Whereas, There is little available research on the chronic exposure of these compounds in personal care products or on the cross-reactivity of using multiple products[5]; and

Whereas, While one product may contain a level of these ingredients that have been deemed safe, continuous use and use of several products containing these ingredients can easily expose men and women to levels that are beyond what has been defined as safe[5,13]; and

Whereas, The FD&C Act does not require the FDA to recall potentially dangerous items or monitor the ingredients used in products[2]; and

Whereas, The FD&C Act is focused mainly on regulating misbranded products or falsely packaged products; additionally, labeling products as natural or organic does not qualify as misbranding[2]; and

Whereas, The FD&C Act does not require cosmetic firms to register their establishments or list their product formulations with FDA[2]; and

Whereas, The European Union has already banned nearly 1,400 chemicals from cosmetics and has required premarket safety assessments, mandatory registration and government authorization for the use of materials[21]; in comparison, the United States has banned only 30 chemicals from use in personal care product formulation[22]; and

Whereas, The Canadian government regularly updates the Cosmetic Ingredient Hotlist in accordance with the Cosmetics Regulation that includes nearly 600 chemicals and contaminants prohibited and restricted from use in cosmetics[23]; and

Whereas, The Personal Care Products Safety Act has been introduced in Congress and would provide the FDA authority to recall personal care products that threaten consumer safety, require the FDA to evaluate a minimum of five ingredients found in personal care products each year to determine safety and appropriate use, and require complete label information to be posted online (including ingredients and product warnings) [24]; and therefore be it

RESOLVED, That our AMA encourage Congress and the FDA to legally define the term "personal care products"; and be it further

RESOLVED, That our AMA advocate for the FDA to research ingredients found in personal care products in order to better understand the cross-reactivity of ingredients, chronic usage of personal care products, and establish guidelines for safe usage of personal care products; and be it further

RESOLVED, That our AMA amend H-440.855 by insertion and deletion as follows, to broaden the scope of advocacy on this issue:

National Cosmetics Registry and Regulation H-440.855

1. Our AMA: (a) supports the creation of a publicly available registry of all ~~cosmetics~~ <u>personal care products</u> and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and

Drug Administration with sufficient authority to recall ~~cosmetic products~~ personal care products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.
; and be it further

RESOLVED, That our AMA-MSS amend 270.021MSS by insertion and deletion as follows:

National Cosmetics Registry and Regulation 270.021MSS
AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all ~~cosmetics~~ personal care products and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall ~~cosmetic products~~ personal care 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)
; and be it further

RESOLVED, That our AMA-MSS amend 525.009MSS by insertion and deletion as follows:

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products 525.009MSS
That our AMA-MSS support improved consumer reporting of ingredients that may be harmful in ~~cosmetic and feminine hygiene products~~ personal care products, including but not limited to cosmetics and feminine hygiene products; (2) That our AMA-MSS support health professionals in counseling patients about the known risks of toxic ingredients in ~~beauty and~~ personal care products, including but not limited to cosmetics and feminine hygiene products. (MSS Res 27-I-17)

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

National Cosmetics Registry and Regulation H-440.855

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.

BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17

National Cosmetics Registry and Regulation 270.021MSS

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)

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products 525.009MSS

That our AMA-MSS support improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; (2) That our AMA-MSS support 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 37
(I-19)

Introduced by: Region 3; Christina Case, Hannah Meissner, Christine Crigler, Creighton University School of Medicine; Sanika Satoskar, Rishitha Panditi, Northeast Ohio Medical University; Peter Joo, University of Rochester School of Medicine and Dentistry

Subject: Support for Mental Health Absences for Students and Residents

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The World Health Organization (WHO) defines mental health as, “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community,” [1]; and

Whereas, Depression is the leading cause of disability worldwide[2]; and

Whereas, Global prevalence of depression amongst medical students from years 1 through 3 is 28% with a higher rate of depression amongst first-year medical students globally at 33.5%[3]; and

Whereas, Only 12.9% of medical students worldwide seek treatment for depression[3]; and

Whereas, Prevalence of depression in the general population is 9.3% among 18- to 25-year-olds and 7.2% among 26- to 49-year-olds, compared to 28% among medical students[4]; and

Whereas, Medical students also suffer from anxiety, burnout, suicidal ideation, and substance abuse[5]; and

Whereas, The stigma of perfection amongst the medical community places significant strain on medical students, which contributes to a delay in seeking mental health care[6]; and

Whereas, Studies have shown that matriculating medical students prior to attending medical school had better mental health across a variety of specific domains compared to age similar controls[7,8]; and

Whereas, There is an apparent shift from students being at a lower risk of distress at the start of medical school to a higher risk during medical school and subsequent stages of their career, which supports the concern that the training process contributes to the deterioration of mental health in developing doctors[8]; and

Whereas, Prevalence of depression or depressive symptoms among resident physicians was 28.8%, ranging from 20.9% to 43.2% depending on the screening instrument used in the studies[9]; and

Whereas, This suggests that medical students and residents are suffering from mental health ailments and therefore should have access to mental health treatment options; and

Whereas, Multiple states have passed bills allowing mental health concerns to be an excusable sick day[10-12]; and

Whereas, Students can currently take days off for physical ailments by using sick days; and

Whereas, Employees may request protected time off due to mental health conditions under Family and Medical Leave Act and the Americans with Disabilities Act and cannot be discriminated against on the basis of health[13,14]; therefore be it

RESOLVED, That our AMA-MSS support mental health as a valid use of a “sick day" for all students.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970
Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate andgraduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

Medical and Health Student Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.

Access to Confidential Health Services for Medical Students and Physicians H-295.858
Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools andresidency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk

factors for burnout, depression and suicide across the continuum of medical education. 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Support Groups-295.001 MSS
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.

Expansion of Student Health Services-295.137 MSS
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.

The Residency Match Process-310.001 MSS
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 the AMA 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 AMAMSS 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.

Preventing Resident Physician Suicide-310.054 MSS
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.

Stigmatization of Mental Health Disorders within the Medical Profession-354.004 MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 38
(I-19)

Introduced by: Region 2

Subject: Report and Recommendations on the Residency Application Process

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The residency application process is protracted, expensive, and often lacks transparency[1]; and

Whereas, An increasing number of applicants and increased competitiveness of The Match leads students to apply to more programs[2]; and

Whereas, Current residency interview practices are inefficient for both applicants and programs including disorganized interview offers, scheduling as well as excessive numbers of applicant interviews[3-4]; and

Whereas, Obtaining a date and time for an interview can be extremely difficult especially when slots fill up quickly, within seconds, despite prompt responses to invitations[5]; and

Whereas, a 2016 article written by Duke Residency Program Director Liana Puscas highlights issues with interview cancellations by applicants and offers solutions such as a limitation to one interview acceptance per applicant per day as well as formal rounds of interview offers[6];

Whereas, By using a “rolling” method for invitations, applicants can not anticipate when a program’s invitation will arrive, forcing them to always be available to check and respond to emails or risk the chance that an interview will be taken by another applicant[7]; and

Whereas, A 2019 Academy of Management Proceedings article on electronic communications found that constantly checking emails is anxiety provoking for individuals as well as their significant others[8]; and

Whereas, There is an increased focus on medical student wellbeing and reduction of anxiety[9]; and

Whereas, Through AMA’s Reimagining Residency initiative, the Association of Professors of Gynecology and Obstetrics created specialty-wide standards for the Ob-Gyn Residency Application and Interview Processes such as allowing applicants a minimum of 72 hours after an interview invitation email to respond[10]; and

Whereas, Our MSS has passed policy to recognize the need for improved communication between programs and applicants (310.019 MSS); and

Whereas, Our AMA has passed policy to improve the residency application process for applicants (H-310.998); therefore be it

RESOLVED, That our AMA study existing communication practices during the residency application process; and be it further

RESOLVED, That our AMA produce best practice guidelines for communication throughout the residency application process between residency programs and applicants.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Residency Interview Schedules H-310.998
1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA

encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

Policy Suggestions to Improve the National Resident Matching Program D-310.974
Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage

the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.

Notification of Interview Decision to Residency Program Applicants 310.019 MSS
AMA-MSS will ask the AMA to strongly encourage residency programs to inform applicants in a timely manner about their interview status and provide a time frame of notification dates in the application materials. (MSS Sub Res 26, A-97) (AMA Res 302, I-97 Adopted [H-310.998]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

The Residency Match Process 310.001 MSS
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 the AMA 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).

Reducing the Financial and Educational Costs of Residency Interviews 305.074MSS
That our AMA 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, and (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews. And that the AMA-MSS consider the following strategies to address the

high cost of interviewing for residency: (a) considering producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (b) creating and/or promote specific websites related to med student travel, and (c) providing or recommending an online forum where students can accommodate other medical students who are interviewing in their area. (Sub Res 2, A-12) (GC Rep A, A-14)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 39
(I-19)

Introduced by: Region 1; Poulomee Tripathi, Monika Satoskar, Northeast Ohio Medical University; Rebecca Hamburger, Central Michigan University College of Medicine

Subject: Protecting Medical Student Access to Abortion Education and Training

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Abortion is a legal medical procedure in the United States as a result of the 1973 U.S. Supreme Court decision in *Roe v. Wade* recognizing a woman's constitutional right to an abortion[1]; and

Whereas*,* The U.S. Supreme Court has reaffirmed the right to an abortion in subsequent decisions holding that a state cannot ban abortion before viability, the point at which a fetus can survive outside the uterus, and that any restriction on abortion after viability must contain exceptions to protect the life and health of the woman[2]; and

Whereas, Following the national legalization of abortion with *Roe v. Wade* and the resultant increase in physician education and skill regarding pregnancy termination procedures, deaths from legal abortions declined fivefold[3]; and

Whereas, Nearly half (45%) of all pregnancies among U.S. women are unintended, and about 4 in 10 of these unintended pregnancies were terminated by abortion[4]; and

Whereas, Sixteen percent of all pregnancies (excluding miscarriages) in 2015 ended in abortion with approximately 638,169 abortions reported to the CDC in 2015 and the abortion rate in 2015 being 11.8 abortions per 1,000 women aged 15–44[5]; and

Whereas, It is estimated one in 20 U.S. women (5%) will have an abortion by age 20, about one in five women (19%) will have an abortion by age 30, and about one in four women (24%) will have an abortion by age 45[6]; and

Whereas, These numbers may be even higher given that underreporting of abortions is common in nationally representative surveys[7]; and

Whereas, Pregnancy options counseling, which is defined as providing non-directive, evidence-based information to newly diagnosed pregnant women about their options for continuing *or terminating a pregnancy* and referrals as necessary, is an integral part of the public health prevention framework for addressing unintended pregnancy and is considered a clinical best practice in the United States[8,9]; and

Whereas, A study analyzing data from the Medical Expenditure Panel Survey from 2002-2011 found that among reproductive-age women, 42.6% were found to receive care including, but not limited to, pregnancy care from solely a family physician, an additional 21.5% received care

from a family physician or general internist in addition to receiving care from an OB/GYN, and 28.6% received their care from solely an OB/GYN[10]; and

Whereas, A 2018 study analyzing data from the Nationwide Emergency Department Sample Survey from 2009-2013 found that among all Emergency Department (ED) visits by women aged 15–49 (189,480,685), 0.01% (27,941) were abortion-related[11]; and

Whereas, The large number of abortion-related ED visits demonstrates that many different types of physicians, not just abortion providers, may have to counsel patients on abortion options and/or care for patients whose health has been affected by an abortion[11]; and

Whereas, Recent studies have found U.S. medical students may be under-prepared to address essential sexual health issues in future clinical practice and have recommended increased integration of sexual health curricula into medical schools' curriculum specifically in the area of family planning[12-14]; and

Whereas, A 2009 study found that only 60% of U.S. medical schools surveyed reported any type of preclinical abortion-related education[15]; and

Whereas, A 2005 study found that 17% of clerkship directors surveyed reported no formal education regarding abortion either in the preclinical or clinical years and 23% reported no formal abortion education provided during third-year OB-GYN rotations[16]; and

Whereas, A 2011 survey of 131 third year medical students at the University of Colorado found that while 80% wanted didactic training on abortion, 57% reported no formal didactic training on abortion, only 24% had rotated through a clinic that provided abortion, and 45% reported unsatisfactory clinical opportunities with regards to abortion training[17]; and

Whereas, A 2015 study of 4th year medical students taking a family planning elective found that 72% of the students reported taking the elective due to a need for greater exposure to family planning care, 48% indicated the elective was necessary to obtain knowledge not available to them during their third-year clerkships, and 21% reported taking the elective in order to learn about abortions and how to perform them as they were not previously given this education[18]; and

Whereas, A 2014 study found that among 362 OB-GYN residents, representing 161 of the 240 OBGYN residency programs within the U.S., 54% reported routine training on abortion, 30% reported opt-in training, and 16% reported that no abortion training was available[19]; and

Whereas, A 2018 study surveying 190 OBGYN residency program directors representing 79% of all OBGYN residency directors found that 64% reported routine abortion training with dedicated time was offered within their residency program, 31% reported only optional abortion training being offered, and 5% reported abortion training was not available[20]; and

Whereas, The American College of Obstetricians and Gynecologists formally recommends integrated medical education on abortion and universal opt-out training policies for medical students and residents[21]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology has stated "All programs must have an established curriculum for family planning, including for complications of abortions and provisions for the opportunity for direct procedural training in terminations of pregnancy for those residents who desire it"[22]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology stated in a 2017 report that programs must allow residents to "opt out" rather than "opt in" to family planning curriculum, education, and training which includes abortions and that the Committee would consider a program with an "opt out" curriculum to be in substantial compliance with the requirements whereas a program with an "opt in" curriculum would be non-compliant with the requirements[22]; and

Whereas, The Association of American Medical Colleges (AAMC) which sponsors, in partnership with the AMA, the Liaison Committee on Medical Education (LCME) has affirmed its support for comprehensive options counseling in regard to reproductive care and its support of the ACGME's guidelines for offering opt-out abortion education[23]; and

Whereas, The AMA sued the Trump Administration over a new executive order that prevents clinics from receiving Title X funding if they provide, counsel patients regarding, or refer patients out for abortions, which demonstrates the AMA's consistent support for access to abortion and comprehensive options counseling that includes abortion[24]; therefore be it

RESOLVED, That our AMA amend policy H-295.923, Medical Training and Termination of Pregnancy by insertion as follows:

Medical Training and Termination of Pregnancy, H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Although observation of, attendance at, or any direct or indirect participation in abortion procedures should not be required, our AMA does support opt-out curriculum requirements on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Medical Training and Termination of Pregnancy H-295.923
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17

Abortion H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10

E-4.2.7 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law. Issued: 2016

Oppose the Criminalization of Self-Induced Abortion H-5.980
Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion. Res. 007, A-18

Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies D-310.954
Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. Res. 317, A-13

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 40
(I-19)

Introduced by: Region 3; Region 5; Region 7

Subject: Support for the Development of Guidelines Preventing Discrimination for People Seeking Preventive Medications

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Recent advances in science and medicine have allowed for the development of medications that can be used to prevent disease transmission or be prescribed during severe health complications (e.g. opioid overdose)[1,2]; and

Whereas, Preventative treatments for a myriad of diseases have positive clinical outcomes[3,4]; and

Whereas, HIV Pre-Exposure Prophylaxis (PrEP), a combination of tenofovir and emtricitabine, lowers the risk of a person not infected with HIV from contracting HIV; taken daily it reduces the risk of sexual transmission of HIV by more than 95% in the general population and by more than 70% in injection drug users[2]; and

Whereas, Opioid overdose deaths can be prevented by the use of naloxone hydrochloride, a competitive antagonist against the mu-opioid receptor, which can counteract the effects of opioids to reverse an overdose[5,6]; and

Whereas, Between 1996 and 2014, 644 local sites in 30 states and the District of Columbia distributed 152,283 naloxone kits and reported 26,463 successful drug overdose reversals[7]; and

Whereas, A 2-year intervention study demonstrated that patients on long-term opioids who were prescribed naloxone had 47% fewer opioid-related ED visits per month in the six months and 63% visits in the 12 months following the prescription compared to patients who did not receive naloxone[8]; and

Whereas, Studies have shown that police officers and bystanders who are trained to administer naloxone resulted in decreases in opioid related deaths ranging from 20% to 78%[7,9,10]; and

Whereas, The AMA's current policy supports the use of and adequate insurance coverage of general preventative care services (H425.987); and

Whereas, Preventive care treatments that are not screenings or vaccinations fall into a grey area regarding insurance coverage and discrimination[11,12]; and

Whereas, The Affordable Care Act makes it illegal for health insurance companies to deny coverage or increase insurance prices due to a pre-existing condition[13]; and

Whereas, "Pre-existing condition" typically refers to chronic illnesses and diseases, such as diabetes, cancer, chronic obstructive pulmonary disease, or sleep apnea[13]; and

Whereas, A 2018 study demonstrated that if the preexisting conditions' required coverage were repealed, this population would have increased out-of-pocket costs, such as tripled costs of patients with cancer or diabetes, and a rise in costs by 27 to 39 percent for arthritis, asthma, and hypertension[14]; and

Whereas, The fact that medications purchased to prevent disease (e.g. PrEP) or health complications not directly associated with a current disease (e.g. overdose) are not considered to pertain to pre-existing conditions results in discrimination against people seeking preventive care[11,12,13]; and

Whereas, A study found that high-risk individuals taking PrEP did not report any increases in sexual or drug-related risk behaviors, and there has been a decrease in the incidence of HIV since the introduction of PrEP[15,16]; and

Whereas, Reviews have found that expanding the supply of naloxone is not associated with compensatory drug use or greater risk-taking[17,18]; and

Whereas, Naloxone can be carried by patients, family members, friends, healthcare workers, and members of the community to save the life of an individual experiencing opioid overdose[19]; and

Whereas, Many people who purchase and use naloxone are friends, family, and community members who are not at risk of opioid overdose themselves, which means that the purchase of naloxone is not indicative of overdose risk[10,20–22]; and

Whereas, There is increasing evidence that insurance companies and other organizations are discriminating against individuals who purchase these medications[15,17,18]; and

Whereas, At least 16 instances have been reported in which an individual using PrEP has been denied disability, long-term care, or life insurance or provided with lower-quality or higher-cost coverage[11,23–25]; and

Whereas, As a result of allegations of discrimination in two separate legal settlements in Massachusetts, the insurer Mutual of Omaha has agreed to no longer deny coverage to individuals using PrEP[26]; and

Whereas, In Massachusetts, a state with a standing order allowing healthcare workers to purchase naloxone, more than a half dozen employees at Boston Medical Center were denied life and disability insurance due to receipt of naloxone, and there is evidence that this has occurred in other states, including New York and Alaska[27–29]; and

Whereas, As it pertains to naloxone, some insurance regulators are making an effort to prevent this type of discrimination, however, it is important to expand awareness of these preventive medications in a way that prevents future discrimination as other medications arrive on the market[30-31]; and

Whereas, In March 2019, the National Council of Insurance Legislators (NCOIL) issued a resolution to prevent a denial of life insurance coverage to those who carry a naloxone prescription[31]; and

Whereas, In May 2019, the New York State Senate passed a bill allowing nurses and other healthcare providers to obtain a prescription for naloxone without insurance repercussions[27]; and

Whereas, In June 2019, the New Jersey Department of Banking and Insurance issued a bulletin protecting against discrimination in the issuance of life insurance policies for people who have obtained naloxone and HIV preventative medications[30]; therefore be it

RESOLVED, That our AMA amend Preventive Medicine Services H-425.987 as follows:

Preventive Medicine Services H-425.987
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; ~~and~~ (C) appropriate reimbursement and coding for established preventive services; and (D) support research into the possibility of classifying "preventive care" as a class under which individuals are protected against discrimination from insurance, employers, or other agencies in the same manner by which pre-existing conditions are protected.
; and be it further

RESOLVED, That our AMA amend Insurance Underwriting Reform H-185.947 as follows:

Insurance Underwriting Reform H-185.947
Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality; and (3) urges any insurance provider to accept appropriately amended medical records when underwriting decisions require medical record review, (4) urges any insurance provider to not make any underwriting decisions based on prescription drug information that is not directly related to the applicant's health status in the insurance underwriting process.
; and be it further

RESOLVED, That our AMA amend Increasing Availability of Naloxone H-95.932 as follows:

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA advocates that individuals are not denied or face discriminatory increases in cost of health, long-term care, life, or disability insurance on the basis of naloxone prescription or use.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS 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 are not denied any insurance on the basis of PrEP use.

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Insurance Underwriting Reform H-185.947
Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality

Preventive Medicine Services H-425.987

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services.

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state
based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the
outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies
report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Prescription Drug Monitoring Program Confidentiality H-95.946
Our AMA will:
(1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial;
(2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and

(3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

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; and
D. encourages physicians to query a state’s-controlled substances database for information on their patients on controlled substances.
3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Naloxone Administration and Heroin Overdose 100.007MSS
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.

Promoting Prevention of Fatal Opioid Overdose 100.010MSS

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 encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

OTC Availability of Naloxone 100.013MSS
Ask the AMA to support the study of OTC availability of Naloxone.

Restrictions on Use of Physician Prescribing Data for Commercial Purposes 120.009MSS
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.

Modernization of HIV Specific Criminal Laws 20.019MSS
AMA-MSS will ask the AMA to amend policy H20.914 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. (MSS Res 37, I-13) (AMA Res 2, A-14 Substitute Res 2 Adopted)

Increase Access to HIV PrEP for At-Risk Individuals 20.020MSS
AMA-MSS supports PrEP referral at needle exchange sites. (MSS Res 26, A-17)

Protecting Patient Access to Health Insurance and Affordable Care 165.019MSS
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])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 41
(I-19)

Introduced by: Region 1; Kajal Madan, Northeast Ohio Medical University; Imaima Casubhoy, University of Missouri Kansas City School of Medicine

Subject: Increasing Access to Menstrual Hygiene Products in School Settings

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Organizations including the United Nations and Human Rights Watch have classified menstrual hygiene as a human rights issue[4]; and

Whereas, The AMA considers menstruation a normal bodily function and considers menstrual products as necessities for women per AMA policy H-525.974; and

Whereas, In 2018, the estimated life-time cost of menstrual products for an individual in the United States was $1,773.33[2]; and

Whereas, Two-thirds of low-income women in the United States of America were unable to afford menstrual products in 2018[1]; and

Whereas, The use of make-shift menstrual sanitation products and neglected menstrual hygiene increases the risk of negative health effects including toxic shock syndrome, reproductive tract infections (RTI), and other vaginal diseases[1,3]; and

Whereas, School aged children in the United States who are unprepared for menarche have increased rates associated with depression, substance abuse, delinquency, and school dropout[5]; and

Whereas, The 2017 Always Confidence & Puberty Survey showed that one in five school aged girls in the United States have left school early or missed an entire day of school due to lack of access to menstrual products[6,7]; and

Whereas, The use of disposable pads in Indian schools was correlated with lower absentee rates in school aged girls which suggests that providing menstrual products could be an effective solution to the adverse effects associated with inadequate access to menstrual products in the US as well[7]; and

Whereas, Currently five states (i.e., California, Georgia, Illinois, New York, and New Hampshire) have implemented legislation to provide free menstrual products (i.e., tampons, sanitary napkins) in public school restrooms [9,10,11,12,13]; and

Whereas, the movement towards menstrual equity for all is reflected in the recent introduction of a House of Representative bill (H.R.1882) requiring public schools to provide free menstrual products to students; and

Whereas, AMA policy H-170.996 reaffirms local societies establishing relationships with schools to aid in health education, particularly in personal hygiene; and

Whereas, AMA MSS [160.033MSS] already supports the distribution of readily available feminine hygiene products in publicly funded institutions, including schools, however, there currently exists no AMA policy on the same; therefore be it

RESOLVED, That our AMA recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; and be it further

RESOLVED, That our AMA support the distribution of menstrual products and inclusion of menstrual product disposal systems in educational institutions.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA will: (1) Encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; (2) Work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products, including tampons for their needs. Res. 218, A-18

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products. Res. 215, A-16

Establishing Active Liaison with Schools and Colleges H-170.996
Our AMA encourages state and local societies to establish liaison relationships with schools to provide appropriate assistance in health education, particularly personal hygiene, substance misuse, smoking, sexually transmitted disease, quackery, and the role of the physician in maintaining good health. Res. 72, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10

Female Hygiene Products 160.032MSS
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 shelter. MSS Res 17, I-16

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 42
(I-19)

Introduced by: Region 3; Region 5; Peter Joo, University of Rochester; Hannah Meissner, Creighton University School of Medicine; Kate Topalis, Cynthia Tan, University of Connecticut; Neil Rens, Stanford University

Subject: Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States leads the world in solid waste production with 262 million tons per year, with the healthcare industry as its second highest waste-producing industry, accounting for 9% of U.S. energy use and 8% of U.S. greenhouse gas emissions[1-7]; and

Whereas, Approximately 70% of the total waste generated by the healthcare sector is produced by operating rooms and labor and delivery suites, and surgical and medical instrument manufacturing is the leading cause for ozone depletion[8,9]; and

Whereas, According to the Centers for Medicare and Medicaid Services, the cost of healthcare continues to increase each year, estimated at $3.8 trillion in 2019 and projected to increase at an average rate of 5.5% per year until 2027[1,5]; and

Whereas, Expenditures for outpatient surgical care consisted of 36% of all outpatient costs, and inpatient surgical admissions made up 49% of all inpatient healthcare spending in 2017[10]; and

Whereas, It has been shown that decreasing the use of disposable drapes, attire, and other plastic materials in the operating room resulted in savings of thousands of dollars per year with no change in the infection rate[11-16]; and

Whereas, Converting to reusable products in the operating room can reduce up to 65% of operating room waste, diverting up to 25 tons of medical waste and saving up to $150,000 per hospital per year and reducing water, carbon footprint, and volatile organics[17-19]; and

Whereas, A “reusable” device is one that the manufacturer has demonstrated to the FDA that it can safely withstand the harsh sterilization process, compared to “reprocessing” single-use devices, which is the act of sterilizing and reusing devices that the manufacturer has not marketed for reuse, and therefore did not have to meet FDA’s stringent criteria for adequate safe sterilization to be sold[20]; and

Whereas, Single-use devices are not intended to be reused by the original manufacturer, and exposure to heat and chemicals during the sanitation process could weaken the product[21-22]; and

Whereas, Overall, the safety standards for multi-use devices are much higher and stricter than those for single-use devices, and some single-use devices are labeled single-use because there is not sufficient evidence to categorize them as reusable[21.22]; and

Whereas, The U.S. Government Accountability Office released a report in 2008 noting that "neither existing FDA data nor studies performed by others are sufficient to draw definitive conclusions about the safety of reprocessed single use devices compared to similar original devices," [20]; and

Whereas, The Joint Commission International published a report in 2017 to raise awareness of the risks associated with reprocessing certain single use devices and the need for stricter regulatory requirements for third-party re-processors and hospitals that use reprocessed devices[23]; and

Whereas, Even with the increased FDA and Joint Commission oversight, the trends by hospitals and surgical centers to decrease costs by reprocessing devices and utilizing sustainable practices are counteracted by the increased efforts by original manufacturers, who do not reprocess their own single-use devices, to sell more single-use devices and discourage reprocessing practices[24, 25]; and

Whereas, Current policy on the reprocessing of single-use devices (H-480.959) does not adequately promote sustainable practices by the original device manufactures as they continue to increase production of single-use devices and are not held liable once their device labeled "single-use" is reprocessed or reused; therefore be it

RESOLVED, That our AMA advocate for research, development, and marketing of intended multi-use operating room equipment over devices and equipment labeled for "single-use" (i.e. towels, gowns, suctions, and other more complicated devices and surgical tools) with verified similar safety and efficacy profiles; and be it further

RESOLVED, That our AMA opposes regulations regarding sterile technique and use of non-reusable surgical products that lack sufficient evidence base in maintaining patient safety.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Reprocessing of Single-Use Medical Devices H-480.959
1. Our AMA: (a) 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; (b) 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; (c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.
2. Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

Expansion of Hazardous Waste Landfills Over Aquifers H-135.943
Our AMA:
(1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
(2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and (3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

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.

Health Care Expenditures D-155.996
1. Our AMA will work to improve our healthcare system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.
2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Expense of Biohazardous Waste Removal H-135.953

(1)The AMA encourages the Environmental Protection Agency (EPA): (a) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot, and (b) to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution. (2)The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.(3) The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public.

Toxicity of Computers and Electronics Waste H-135.948
Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous electronic waste to developing countries and safely dispose of the waste that cannot be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials.

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Policy to Reduce Waste from Pharmaceutical Sample Packaging H-115.979
Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy.

Recycling of Nursing Home Drugs H-280.959
Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.

Health Care Expenditures D-155.996
1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.
2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Medications Return Program H-135.925
1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications
2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.
3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856
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

Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease 215.001MSS

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)

Recycling 135.006MSS
AMA-MSS encourages and supports all efforts to further hospital recycling. (MSS Sub Res 6, 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)

Statement of Sustainability Principles 135.013MSS
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)

Promotion of Conservation Practices within the AMA 135.005MSS
AMA-MSS will ask the AMA to direct its offices to implement conservation-minded practices whenever feasible. (AMA Res 16, A-91 Adopted [G-630.100]) (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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 43
(I-19)

Introduced by:	Region 3; Region 4; Region 5; Ryan Chiu, University of Illinois College of Medicine
Subject:	Ethics and Security of Brain-Computer Interfaces
Referred to:	MSS Reference Committee (Pauline Huynh, Chair)

Whereas, A brain-computer interface is a device that enables communication between neurons and a computer[1,2]; and

Whereas, Brain-computer interfaces have the potential to drastically expand the bounds of medicine: enabling movement for those who have been paralyzed, restoring vision for the blind, even connecting artificial intelligence to the human brain[3-7]; and

Whereas, In July of 2019, Neuralink announced its creation of a Bluetooth connected chip with 3072 electrodes that it hopes to bring to clinical trials in late 2020[8]; and

Whereas, The exciting advances in brain-computer interfaces bring about important questions of ethics and security that are not adequately addressed by current laws[9]; and

Whereas, The first Global Neuroethics Conference convened in August of 2019 to discuss ethical issues related to brain-computer interfaces and establish neuro-specific rights including cognitive liberty, mental privacy, and mental integrity[9-11]; and

Whereas, Cognitive liberty, the freedom to use or not use neurotechnologies, could be threatened by the military's use of transcranial direct current stimulation to enhance multitasking, arousal, and visual recognition, thus violating the Hippocratic principle of patient autonomy[9,12-15]; and

Whereas, Mental privacy, the right to control the distribution and use of one's brain-derived data, could be threatened by hackable Bluetooth devices and high accuracy fMRI lie detectors[9,16-18]; and

Whereas, Mental integrity, the freedom from unwanted external manipulations of one's mental processes, could be threatened by Deep-Brain Stimulation devices that can be hacked, techniques that can eliminate and then reactivate memories in rats, or neuromodulation that increases perceptibility to certain beliefs[9,18-22]; and

Whereas, "The right and freedom to control one's own consciousness and electrochemical thought processes is the necessary substrate for just about every other freedom" (Dr. Wrye Sententia, Director of the Center for Cognitive Liberty and Ethics)[23]; and

Whereas, Brain-computer interface implantation is associated with various surgical complications, such as glial scarring (which can impede the function of the surrounding implant),

decreased neuroplasticity as a result of foreign body interference, acute trauma to the brain from surgical intervention, and surgical site infection[24-28]; and

Whereas, The sequencing of the human genome created new ethical concerns leading to the Universal Declaration of Human Genome and Human Rights, similarly, the advances in neurotechnologies have created new ethical concerns that need to be addressed[29-31]; and

Whereas, Our AMA believes that "physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to release a patient's genetic information to third parties only with the patient's informed consent" (Code of Medical Ethics Opinion, 4.1.3 Third-Party Access to Genetic Information)

Whereas, Our AMA "supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process" (The Next Transformative Project: In Support of the BRAIN Initiative H-460.904); and

Whereas, Our AMA affirms that "there exists a basic right of patients to privacy of their medical information and records" (Patient Privacy and Confidentiality H-315.983) and that "informed consent to medical treatment is fundamental in both ethics and law" (Code of Medical Ethics,2.1.1 Informed Consent); therefore be it

RESOLVED, That our AMA support the neuro-specific human rights of cognitive liberty, mental privacy, and mental integrity defined as follows:

- Cognitive liberty - the freedom to use or not use neurotechnologies
- Mental privacy - the right to control the distribution and use of one's brain-derived data
- Mental integrity - the freedom from unwanted external manipulations of one's mental processes

; and be it further

RESOLVED, That our AMA support research efforts investigating brain-computer interfaces, with emphasis on the safety and security of these devices, and be it further

RESOLVED, That our AMA support legislation that makes it illegal to collect information from or send information to a brain-computer interface without informed consent.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

The Next Transformative Project: In Support of the BRAIN Initiative H-460.904
Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.

Augmented Intelligence in Healthcare H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of healthcare AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Augmented Intelligence in Healthcare 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.

4.1.3 Third-Party Access to Genetic Information
The rapid pace of development and dissemination of genetic testing has made it possible to generate information about individuals across a wide and growing spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual's health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information.

Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual.

Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to:

(a) Maintain the confidentiality of the patient's health information, including genetic information.
(b) Release a patient's genetic information to third parties only with the patient's informed consent.
(c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient's request and with their informed consent.

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as

other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of

identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

Technology and the Practice of Medicine G-615.035
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.

485.003MSS: Machine Intelligence in Healthcare
That our AMA-MSS supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) That our AMA-MSS 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) That our AMA-MSS 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) That our AMA-MSS encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) That our AMA-MSS 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 44
(I-19)

Introduced by: Region 1; Region 2; Yu Kyung Lee, Yale School of Medicine

Subject: Classification and Surveillance of Maternal Mortality

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States is the only developed country in the world that reported a projected increase in maternal mortality rate from 2003-2013, despite global trends of accelerated decline[1-3]; and

Whereas, Since 2007, the U.S. has not published an official yearly maternal mortality rate in the annual National Vital Statistics Report, which is the publication used to compare mortality rates internationally[4,5];

Whereas, A new question format for the U.S. Standard Certificate of Death introduced in 2003 was intended to standardize the collection of data related to pregnancy, childbirth, and puerperium, but was implemented incongruously across states, leading to increased misclassifications of maternal deaths[5]; and

Whereas, A lack of standardized definitions and terminology between state and national health organizations when attempting to quantify state-wide and national maternal mortality rates has led to inconsistencies and inaccuracies when reporting these quantities[6]; and

Whereas, Due to the difficulty of interpreting the inconsistent data, the U.S. has stopped publishing the official maternal mortality rate[2,5]; and

Whereas, Without a reliable annual report of maternal mortality rate, an accurate assessment of annual trends and international comparisons cannot be made[2, 4-5]; and

Whereas, Although the Centers for Disease Control tracks maternal mortality data and periodically makes it available to the public, the CDC is reliant on voluntary reporting and does not generate an annual report of maternal mortality rate[3,7]; and

Whereas, Due to concerns about privacy, only researchers who have undergone Institutional Review Board approvals are able to gain access to maternal mortality data[7]; and

Whereas, Despite significant efforts to reduce the maternal mortality rate in the U.S.—such as Preventing Maternal Deaths Act of 2018, which provides the funding necessary to study maternal morbidity and mortality data at the state levels—dissemination of data to the public has been delayed[2,6,8]; and

Whereas, In 2010, Amnesty International issued a highly critical report on the state of maternal mortality in the U.S., recommending that maternal mortality and morbidity trends be made publicly available and states should be mandated to report such data to federal agencies annually[8]; however, the 2019 Maternal Mortality Summit report from the U.S. Department of

Health and Human Services Health Resources and Services Administration still found the need to improve the quality and availability of national data on maternal mortality[6]; and

Whereas, Unlike developing countries that face difficulties in tracking mortality rates overall, the United States already has a reliable national vital statistics report system in place to enable identification of maternal deaths, as long as states are able to utilize consistent reporting standards[10]; and

Whereas, Existing AMA policies D-420.993, D-245.994, and H-60.909 on maternal mortality rate and maternal mortality surveillance promote state-level action and federal support for state programs that monitor maternal mortality and morbidity, but falls short of specifying the need for a reliable, standardized national maternal mortality report, limiting the impact of current AMA policies for they fail to elucidate the national trends of maternal mortality and morbidity; and

Whereas, As maternal mortality is a key public health issue that concerns all healthcare providers—not just those who research maternal mortality—the barriers to access information regarding recent maternal mortality rates should be alleviated[6]; and

Whereas, Having annual maternal mortality rate reports can help healthcare providers and society monitor the efforts to reduce maternal mortality and keep such programs accountable[7,8]; therefore be it

RESOLVED, Our AMA advocate to the Centers for Disease Control and Prevention (CDC) for an annual release of the national maternal mortality rate in the United States by mandating consistent reporting by all states.

RESOLVED, Our AMA will collaborate with relevant stakeholders to advocate for a reliable, accurate, and standardized definition of maternal mortality that will be implemented across states for tracking data on maternal mortality.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Disparities in Maternal Mortality D-420.993
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.
CSAPH Rep. 3, A-09Appended: Res. 403, A-11Appended: Res. 417, A-18

Infant Mortality D-245.994
(1) Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers. (2) Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
Res. 410, A-10

State Maternal Mortality Review Committees H-60.909
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.
Res. 911, I-17

Infant Mortality Statistics H-245.998
The AMA (1) requests that all countries use a standard form of reporting births in their country and the deaths that result per 1,000 live births based on rules and regulations set up by the World Health Organization; and (2) supports publicizing that the medical profession is vitally

concerned with infant mortality rates and pledges to continue its efforts to decrease the infant mortality rates in the US to the lowest rate possible.
Res. 7, I-71Reaffirmed: CLRPD Rep. C, A-89Reaffirmed by BOT Rep. 8, A-97Reaffirmed: CSAPH Rep. 3, A-07Reaffirmed: CSAPH Rep. 01, A-17

International Infant Mortality Data H-245.987
The AMA supports taking steps to make the public aware that baseline data differences exist in comparison studies, so that information presented for political purposes may be misleading.
BOT Rep. HH, A-91Reaffirmed by BOT Rep. 8, A-97Reaffirmed: CSAPH Rep. 3, A-07Modified: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 45
(I-19)

Introduced by: Region 1; Region 7; Student National Medical Association; Andrew Suchan, Northeast Ohio Medical University

Subject: Enfranchisement of Incarcerated Persons

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Per the Code of Laws of the United States of America, a felony is defined as "an offense punishable by a maximum term of imprisonment of more than one year"[1]; and

Whereas, The term "felon" is stigmatizing, and person-first terminology such "people with a history of incarceration," "incarcerated people," or "people with felony convictions" are non-stigmatizing and therefore preferred[2-3]; and

Whereas, Those convicted of felonies, whether in prison or released from prison, face disproportionately higher rates of infectious disease, chronic disease, mental illness, and substance use disorders[4]; and

Whereas, Only Maine and Vermont allow currently and formerly incarcerated people with felony convictions to vote without restriction, as the other 48 states maintain legal barriers to political enfranchisement of these populations[5]; and

Whereas, A 2018 Florida ballot initiative amended the Constitution of Florida to restore voting rights to people convicted of felonies (excluding those convicted of murder and felony sexual offense) upon completion of their sentences, including terms, parole and probationary periods[6]; and

Whereas, Over 6 million Americans were unable to vote in the 2018 midterm elections due to felony disenfranchisement[7]; and

Whereas, Nearly three-fourths of those who are disenfranchised by felony disenfranchisement laws are not currently incarcerated[8]; and

Whereas, Felony disenfranchisement is not merely an issue of inequality of political representation between incarcerated and un-incarcerated people, but also a particularly prominent disparity among medically underserved racial groups, especially Black Americans, who are more than 5 times more likely to be incarcerated than white Americans[9]; and

Whereas, Nationwide, 1 in 13 Black Americans cannot vote because of felony disenfranchisement, representing a disenfranchisement rate 4 times as high as the American population as a whole[10]; and

Whereas, In 2010, approximately 3.9 million voting-age Black Americans—13.2% of the voting-age Black population—were disenfranchised due to current or recent incarceration[11]; and

Whereas, The felony disenfranchisement of incarcerated Black Americans significantly reduces voter turnout within their enfranchised social circles by normalizing a lack of political participation and facilitating the persistent formation of a second-class citizenship identity among enfranchised Black Americans, furthering racial disparities in political participation due to incarceration[12]; and

Whereas, The disenfranchisement of correctional populations decreases the likelihood of public health funding by weakening the political influence of the communities from which incarcerated people come, which tend to be non-white, low-income, dependent on public resources, and supportive of sustained funding of those resources[13-16]; and

Whereas, A review of 34 worldwide studies found an empirical link between political participation and key health outcomes such as infant mortality, maternal mortality, life expectancy at birth, self-rated health, mental wellbeing, and life satisfaction[17]; and

Whereas, A city-level analysis revealed that proportional Black representation on a city council (arising from increased voting among Black constituents) was associated with lower Black neonatal mortality[18]; and

Whereas, Greater state-level disparities in voter turnout between socioeconomic groups, to which the disenfranchisement of correctional populations contributes, is associated with poor self-rated health within that state, even when controlled for income inequality and state median household income[19]; and

Whereas, People with poorer health[20] and with mistrust of political institutions are less likely to vote[21], feeding a vicious cycle of political disengagement and worsening health among currently and formerly incarcerated persons, who are more likely to have poorer health and harbor mistrust of a system that disenfranchised them; and

Whereas, A study of Brazilian elections found that voting technology enabling de facto enfranchisement of less-educated citizens was associated with increased public spending on healthcare and decreased prevalence of low-weight births to less-educated parents[22]; and

Whereas, State electorates that are disproportionately more representative of healthy people spend less on healthcare and have less expansive Medicaid programs[23]; and

Whereas, Our AMA-MSS "supports policies and practices that prevent employers from discriminating against formerly incarcerated individuals"[22] as a means of improving health within that population, suggesting support of other practices and policies that reintegrate recently incarcerated people into society outside of the correctional system, such as the enfranchisement of formerly incarcerated persons[24]; and

Whereas, Our AMA supports "adequate funding [for]" and "access to comprehensive health care" for incarcerated persons to "improve health outcomes among this vulnerable patient population", and felon enfranchisement enables those with felony convictions to participate in the political processes where the longevity of healthcare funding and adequacy of healthcare access for this population is determined[25]; and

Whereas, Our AMA advocates for "the repeal of laws that deny persons with mental illness the right to vote", establishing a precedent for its engagement with issues of political enfranchisement among vulnerable patient populations[26]; therefore be it

RESOLVED, That our AMA recognize that the health and well-being of currently and formerly incarcerated populations, including those convicted of felonies, is connected to the political enfranchisement of those populations; and be it further

RESOLVED, That our AMA urge the enfranchisement of formerly and currently incarcerated persons, including those with felony convictions, as a means of promoting the health of that marginalized patient population.

Fiscal Note: TBD

Date Received: 09/20/2019

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24. 440.074MSS The Effects of Employment Discrimination on the Health of Formerly Incarcerated Individuals
25. Health Care While Incarcerated H-430.986
26. Mental Illness and the Right to Vote H-65.971

RELEVANT AMA AND AMA-MSS POLICY

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00 Reaffirmation I-09 Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16 Appended: Res. 421, A-19 Appended: Res. 426, A-19.

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16 Appended: Res. 417, A-19 Appended: Res. 420, A-19.

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA Rep. 4, A-03 Modified: CSAPH Rep. 1, A-13.

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Amended: Res. 416, I-99 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation I-09 Modified in lieu of Res. 502, A-12 Reaffirmation: I-12.

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

The authors include the following policy only because it invokes the right to vote, and with the understanding that incarcerated Americans face both untrue stereotypes regarding mental health and genuine mental health crises compounded by substandard mental health care:

Mental Illness and the Right to Vote H-65.971
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.
Res. 202, A-10.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 46
(I-19)

Introduced by: Neha Anand, Jack Gatti, Johns Hopkins University School of Medicine;
Christina Nania, University of Texas-McGovern Medical School

Subject: Gun Violence and Mental Illness Stigma in the Media

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, In the wake of recent mass shootings, there have been statements in the media about mental health and gun violence, with examples including "(1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control 'won't prevent' another Newtown (Connecticut school mass shooting)";[1] and

Whereas, Between 2005-2014, an analysis of a sample of national news stories about mental illness showed that 56% of stories mentioned violence related to mental illness and, of those stories, 75% detailed a specific violent event by a person with mental illness - most often a gun violence event (32%) or a mass shooting event (22%);[2] and

Whereas, News media portrayals of mass shooting events that describe the shooter as having serious mental illness increase people's negative attitudes toward those with serious mental illness, heightening desired social distance from and perceived dangerousness of those with serious mental illness;[3] and

Whereas, A 2013 Gallup poll showed that 80% of adult Americans placed blame ("a great deal" and "a fair amount" of blame) on the mental health system for mass shootings, while around 40% blamed easy access to guns;[4] and

Whereas, A 2017 CBS poll found that 68% of Americans believe that better mental health screening could help prevent gun violence;[5] and

Whereas, Experts on gun violence rank other measures to reduce mass shootings, such as banning assault weapons and universal background checks, as more effective than expanding mental health treatment;[6] and

Whereas, Mental health care spending, mental health professionals per capita, and the rate of severe mental health disorders is not higher in the US compared to other developed countries, which have lower rates of mass shootings;[7] and

Whereas, "Most people who are violent are not mentally ill, and most people who are mentally ill are not violent";[8] and

Whereas, Mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides; in contrast, deaths by suicide using firearms account for nearly two-thirds of yearly gun-related deaths, or 20,000 deaths per year;[9] and

Whereas, There is little evidence to support that those diagnosed with mental illness are more likely than anyone else to commit a crime with a gun;[10] and

Whereas, Although some mass shooters are found to have a history of psychiatric illness, no reliable research has suggested that a majority of perpetrators are primarily influenced by serious mental illness;[9]and

Whereas, "Higher rates of firearm ownership are associated with higher rates of overall suicide and firearm suicide";[10] and

Whereas, Stigma toward those with mental illness, including a perception that they are dangerous or aggressive, may deter patients from seeking health care;[11] and

Whereas, Health care professionals may harbor stigma against mental illness;[12] and

Whereas, The American Psychiatric Association, in response to mass shootings in Texas and Ohio, released a statement on August 4th, 2019 stating, "Routinely blaming mass shootings on mental illness is unfounded and stigmatizing. Research has shown that only a very small percentage of violent acts are committed by people who are diagnosed with, or in treatment for, mental illness." and instead pointed to the access and lethality of firearms as greater risk factors for mass shootings;[13] and

Whereas, current AMA president, Dr. Patrice Harris, was quoted saying, "Mass shootings do not equate to mental illness" after the shootings in Texas and Ohio;[14] therefore be it

RESOLVED, That our AMA amend H-145.971, "Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings", by addition to read as follows:

> **Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings, H-145.971**
> Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings, including for careful discussion of mental illness and gun violence.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976
1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings.

Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings, 145.018MSS

Our AMA-MSS asks our 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 47
(I-19)

Introduced by: Shannon Wagner and Josh Kaiser, University of Miami Miller School of Medicine.

Subject: Advocating for Arbitration to Solve Surprise Medical Billing Practices

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Controversy surrounding proper legislative action to address surprise medical billing, the practice of charging patients out-of-network (OON) rates within in-network hospital settings, remains a relevant yet unresolved issue within the health policy arena[1-5]; and

Whereas, Surprise medical billing affects approximately 1 in 6 Americans, and 18 percent of patients with large group employer insurance have received at least one claim from an out-of-network provider during an inpatient admission[6]; and

Whereas, A nationwide study of medical claims data found that 20 percent of hospital inpatient admissions from the emergency department (ED), 14 percent of outpatient visits to the ED, and 9 percent of elective inpatient admissions have resulted in a surprise medical bill[7]; and

Whereas, A 2019 analysis using claims data from a large commercial insurer found the incidence of surprise billing rose from 32.3 to 42.8 percent from 2010 to 2016, with the average cost of bills more than doubling within both ED and inpatient settings[8]; and

Whereas, A 2018 Kaiser Family Foundation Health Tracking poll reports that 39 percent of insured, nonelderly adults have received an unexpected medical bill within the past year, with 13 percent reporting costs totaling over $2,000[9]; and

Whereas, As of July 2019, only 13 states have codified comprehensive surprise billing protections for patients, while 27 states and the District of Columbia have none at all[10,11]; and

Whereas, Sixty-one percent of private insurance plans fall outside state jurisdiction as self-funded ERISA plans, further necessitating federal action to protect patients from burdensome bills they neither deserve nor can afford[12]; and

Whereas, In the absence of federal protections, state-level surprise billing policy strategies have included median rate benchmarking, percentage-of-Medicare benchmarking, or internal dispute resolutions (IDRs) to settle exorbitant OON charges[9]; and

Whereas, The state of New York (NY) has successfully enacted comprehensive, baseball arbitration-style IDR policy for settling claim disputes between payers and facilities, without attributing additional financial risk to patients[13,14]; and

Whereas, The NY law stipulates that if a facility does not accept a payer's offer, it may initiate an independent and binding arbitration process in which an Independent Dispute Resolution Entity (IDRE) acts as an objective arbiter[13,15]; and

Whereas, The IDRE has the power to stipulate that either the provider will be paid the payer's original offering, or the payer will pay the provider's original charge, thereby incentivizing both parties to offer reasonable initial charges or payments to the other entity, or to negotiate independently in good faith[15]; and

Whereas, In response to these new policies, OON rate-charging in New York has declined 34 percent from 2013 to 2015, and has declined by 6.8 percent compared to other New England states[15]; and

Whereas, In the year following the enactment of arbitration, the average silver-priced premium in the NY marketplace increased just 0.5 percent while inflation increased 1.0 percent, indicating the IDR process did not promote a reactionary increase in insurance premiums in the state[16,17]; and

Whereas, In response to the success of the NY law, the states of New Jersey, Washington, and Texas have recently also codified baseball-style arbitration into their surprise billing legislation efforts[18-20]; and

Whereas, In contrast, states utilizing benchmarking and/or rate-setting have received reports of premium increases, low physician compensation, narrow networks, and patient complaints about access to care[21,22]; and

Whereas, Existing AMA policy promotes the use of mediation when physician's fees are not accounted for in minimum coverage standards, and supports arbitration as an AMA-approved model for conflict resolution within doctor-patient contexts[23,24]; therefore be it

RESOLVED, That our AMA advocate for federal legislation that pre-empts state laws and mandates arbitration as the primary means to eradicate balanced bills and resolve resultant payment disputes between payers and provider.

Fiscal Note: TBD

Date Received: 09/20/2019

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23. Out-of-Network Care, H-285.904. Mod. A-19.
24. Binding Arbitration, H-435.945. A-11.

RELEVANT AMA AND AMA-MSS POLICY

Balance Billing for All Physicians D-380.996

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Billing Procedures for Emergency Care H-130.978
1. Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms.
2. In the interest of high-quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services.
3. Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Out-of-Network Care H-285.904
Our AMA adopts the following principles related to unanticipated out-of-network care: A) Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider. B) Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans. C) Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur. D) Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians. E) Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. F) Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. G) Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-

network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

Binding Arbitration H-435.945
Our AMA supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 48
(I-19)

Introduced by:	Region 3; Region 4; Louisa Liu, Northeast Ohio Medical University; Tabitha Moses, Wayne State University School of Medicine
Subject:	Support for Standardized Interpreter Training for Medical Students, Residents, and Practicing Physicians
Referred to:	MSS Reference Committee (Pauline Huynh, Chair)

Whereas, The latest census data shows 66.6 million people in the US speak a language other than English at home, with one in every 10 working adults in the U.S. having limited English proficiency (LEP)[8]; and

Whereas, there is a growing need for standardized training to instruct medical students and physicians on how to work with interpreters when treating patients with LEP[1]; and

Whereas, According to Title VI of the Civil Rights Act of 1964 and the U.S. Health and Human Services Executive Order 13166, hospitals and other facilities that offer medical services and receive federal funds must provide “meaningful access” to patients, so they can make informed decisions about their health[7]; and

Whereas, Certified medical interpreters are trained to work with medical terminology in both working languages, while bilingual providers and bystanders are not typically trained in medical terminology of the non-English language[4,5,6]; therefore, the use of professional interpreters, defined as interpreters who have undergone a training and certification process, has been associated with an overall improvement of care for patients with LEP, specifically in increased patient comprehension, decreased communication errors, equalization of health care utilization, improvement in clinical outcomes, and increased satisfaction with communication and clinical services for patients[2,3]and

Whereas, There is currently a shortage in the number of certified medical interpreters in the U.S[13]; and

Whereas; Untrained interpreters have insufficient medical bilingual skills, may use colloquial speech, and have a greater risk of making interpreting errors[14]; and

Whereas, The Agency for Healthcare Research and Quality recently conducted a study that found that although it is mandated for all patients to have access to professional language services, professional interpreters are often underused in the healthcare setting even when available and appropriate[15]; and

Whereas; There is frequent reliance on medical students, residents, and other physicians with only limited proficiency in a particular language or untrained ad-hoc interpreters such as patients’ family members or bilingual clinic staff with other roles despite laws that advise against these practices and the availability of professional interpretation services[9-10,15]; and

Whereas, Although current AMA policy supports the use of medical interpreters in the clinical setting, it does not address the lack of training healthcare providers are receiving regarding their legal obligations to notify patients of their federally mandated right to language services and how best to work with medical interpreters in the clinical setting[4,9,12]; therefore be it

RESOLVED, That our AMA should develop a standardized training module with support from the American Association of Medical Colleges (AAMC) and the Accreditation Council on Graduate Medical Education (ACGME) that could be made available for further education on appropriate interpreter use in the clinical setting; and be it further

RESOLVED, That our AMA make this training module available for referral to medical students as an educational resource on the appropriate manner of working with interpreters.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

D-385.957: Certified Translation and Interpreter Services: Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

D-385.978: Language Interpreters: Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians." This policy stresses the importance of providing proper interpretive services even given the financial barriers.

H-295.897: Enhancing the Cultural Competence of Physicians : 1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys. 3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations. 4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments." This policy encompasses aspects of the author's asks.

H-160.924: Use of Language Interpreters in the Context of the Patient-Physician Relationship: AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and
(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

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." This AMA-MSS policy, though broad, encompasses the scope of the proposed resolution.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 49
(I-19)

Introduced by: Anna Heffron, Andrew Huang, and Zachary Dunton, University of Wisconsin School of Medicine and Public Health

Subject: Support for Warning Labels on Firearm Ammunition Packaging

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Nearly 40,000 firearm-related deaths occurred in the United States in 2017, equating to 12.2 firearm-related deaths per 100,000 population and 109 deaths each day, making this the worst year on record for firearm-related deaths[1]; and

Whereas, Firearm ownership and access contribute to mortality in a multitude of ways, including that firearms are the second-leading cause of death of children in the U.S., over half of the firearm-related deaths in the U.S. are due to suicide and access to a firearm increases suicide risk by seven times, access to a firearm increases the risk of death by homicide by two times, women in the U.S. are 25 times more likely to be killed with firearms than in other high income countries, in homes where domestic violence occurs a firearm increases the risk of women being killed by five times, and so on[1-5]; and

Whereas, Over 40% of Americans live in a household with at least one firearm, but only 44% or fewer store their firearms unloaded and separate from the ammunition, which is recognized as a best practice to reduce the risk of firearm-related suicide and injury6[-10]; and

Whereas, Relatively few federal or state regulations on ammunition exist, despite evidence that reduced availability of ammunition has been associated with reduced firearm-related mortality[7-12]; and

Whereas, Text-based warning labels have been shown to and may be effective in reducing harmful health behaviors such as consumption of high-sugar or nutritionally poor foods, consumption of alcohol, and misuse of medications[13-20]; and

Whereas, A large body of evidence shows graphic warning labels on tobacco packaging, currently in use in more than 100 countries, consistently reduce tobacco use, are more effective at changing behaviors and cognitive patterns than text-only warnings, and are equally effective for many diverse population subgroups, and graphic pictorial warning labels have also been shown to have greater potential benefits than text-based warnings in reducing alcohol use, sugary drink consumption, and gambling[14,21-34,37,38]; and

Whereas, In May 2019, the #DontLookAway campaign proposed requiring graphic warning labels depicting potential harms on firearm ammunition packaging in the U.S. alongside public health statistics concerning firearm-related harms[39,40]; and

Whereas, No published studies currently exist concerning warning labels or graphic warning labels on ammunition or firearms packaging; in the U.S., this may be attributable to restrictions on firearms research while in other developed nations it is likely due to strong restrictions on firearm ownership and purchasing and markedly lower firearm ownership, and ammunition consumption[41-48]; and

Whereas, In 2019, California began implementing Assembly Bill 1525, which requires warning labels detailing firearm risks and firearm regulation laws be included on all packaging of firearms and located on the premises of licensed firearms dealers, illustrating such requirements can be enacted, though no research has yet been published on their effectiveness[49]; and

Whereas, Our AMA supports warning labels on packaging of foods high in added sugars (D-150.974), foods containing high fructose corn syrup (D-150.981), wire-bristle grill brushes (D-10.991), detergents (D-60.967), waterbeds and beanbag furniture (H-245.985), indoor tanning equipment (H-440.839), noise-producing toys (H-440.897), energy beverages (D-150.976), latex-containing products (H-480.970), hand-held devices (H-15.952), and nicotine and tobacco products (H-495.973), and our AMA supports graphic warning labels on tobacco packaging (H-495.989); and

Whereas, Our AMA recognizes firearms as a public health problem (H-145.997) and gun violence as a public health crisis (D-145.995); therefore be it

RESOLVED, Our AMA supports legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum, (a) statistics related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms; and be it further

RESOLVED, Our AMA encourages research into the effectiveness of explicit, picture-based graphic warning labels, depicting the dangers and health hazards of firearm ownership and use, on packaging for firearm ammunition.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Tobacco Product Labeling H-495.989
Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.
4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.

The Health Effects of High Fructose Syrup D-150.981
Our AMA:
(1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;
(2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and
(3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet.

Grill Brush Warning D-10.991
Our AMA will request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

Support for Detergent Poisoning and Child Safety Act D-60.967
1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.
2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method, so children know that the product is dangerous to ingest.
3. Our AMA encourages the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury.

Mandatory Labeling for Waterbeds and Beanbag Furniture H-245.985
The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag.

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

Tanning Parlors: Our AMA supports: (1) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (2) legislation to strengthen state laws to make the consumer as informed and safe as possible; (3) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (4) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (5) the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR ?1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (6) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (7) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (8) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (9) intensified efforts to enforce current regulations.
Sunscreens. Our AMA supports: (1) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.
2. Our AMA supports sunshade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

Noise Induced Hearing Loss In Children And Adolescents H-440.897
1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents.
2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour.
3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL.
4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.

Hazards of Energy Beverages - Their Abuse and Regulation D-150.976
1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).

2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.
3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.

Latex Allergy Warning H-480.970
The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care.

The Dangers of Distraction While Operating Hand-Held Devices H-15.952
1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of handheld communication devices to text message while operating motor vehicles or machinery.
2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and Prevention and other interested stakeholders; and (b) explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers

of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

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.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. 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:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) 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;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) 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;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) 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
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

School Violence H-145.983
Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Control of Non-Detectable Firearms H-145.994
Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Restriction of Assault Weapons H-145.993
Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Guns in Hospitals H-215.977
1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.
D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.
E. Policies should undergo periodic reassessment and evaluation.
F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.

Prevention of Firearm Accidents in Children H-145.990
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976
1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996
Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Safety of Non-powder (Gas-Loaded/Spring-Loaded) Guns H-145.989
It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of non-powder (gas-loaded/spring-loaded) guns.

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.

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.

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994
Our AMA will 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.

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

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.

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.

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.

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.

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:
(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.

145.009MSS Regulation of Handgun Safety and Quality
AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 50
(I-19)

Introduced by: Akhila Padi, Bryana Baginski, University of South Carolina School of Medicine Greenville; Tabitha Moses, Wayne State University School of Medicine; Jack Gatti, John Hopkins University School of Medicine; Arjun Rangan, Medical College of Georgia

Subject: Naloxone Training in Correctional Facilities Prior to Release of People who are Incarcerated

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Approximately 20 million Americans were living with Substance Use Disorder in 2017[1]; and

Whereas, Of the more than 2.3 million people in American prisons and jails, more than 65% meet medical criteria for substance use disorder (SUD)[2]; and

Whereas, Around 75% of individuals in a state prison or local jail who suffer from another mental illness also struggle with SUD[3]; and

Whereas, Less than 10% of formerly incarcerated individuals have access to SUD treatment after their release[4]; and

Whereas, The U.S. prison population is disproportionately comprised of people from vulnerable and marginalized groups, as it is rapidly aging, has a prevalence of serious mental illness 2-4 times that of the general population, high infectious disease burden, fewer than 15% of people with SUD receiving treatment, all while Black and Latinx communities suffer from disproportionately high incarceration rates[5-6]; and

Whereas, In the two weeks after release, it is estimated that recently incarcerated individuals are almost 42 times more likely to die from an opioid-related overdose than the general population, with opioids accounting for almost 50% of all deaths among formerly incarcerated people[4]; and

Whereas, Opioid overdose prevention programs (OOPPs) that include naloxone distribution have been shown to have post-naloxone administration survival rates ranging from 83-100%[7]; and

Whereas, Naloxone education programs have been used to teach community members how to recognize the signs of an overdose, how to use naloxone, and have empowered people who use drugs to recognize how to make choices that reduce the risk of overdose death[8-9]; and

Whereas, Community based opioid overdose prevention programs (OOPPs) have distributed naloxone directly to high-risk patients since 1996, and are estimated to have contributed to the reversal of at least 10,000 overdoses[8,10-11]; and

Whereas, Take-home naloxone training programs have been found to reduce overall mortality among program participants and their surrounding communities, and have a low rate of adverse events[12]; and

Whereas, Naloxone education programs are not just limited to people who use opioids, as recent efforts have been made to train law enforcement officers to use and carry naloxone[13]; and

Whereas, A study involving naloxone distribution and training to at-risk individuals in English prison demonstrated that 76% of individuals shared information about their naloxone training with a family member, 71% carried naloxone with them within the first two weeks of their release, and 21% reported using the naloxone on themselves or another prior to the arrival of a doctor or ambulance[14]; and

Whereas, People who have experienced incarceration are more likely than people without a history of incarceration to be willing to use naloxone as an overdose prevention strategy[15]; and

Whereas, Those who attended training sessions for people who are incarcerated with expected release (within 6 months) showed increased knowledge of the risks and signs of opioid overdose, actions following overdose, and the use of naloxone[16]; and

Whereas, In New York, implementation of a program for soon-to-be-released incarcerated people including education about opioid overdose, naloxone training, and distribution of naloxone free of charge at release yielded 94% of respondents correctly identifying naloxone's function in reversing an opioid overdose, and 93% of respondents recognizing their increased risk of experiencing overdose upon leaving their correctional facility[17]; and

Whereas, Current AMA policy (H-95.932) encourages increasing the availability of naloxone in correctional facilities, but fails to address a lack of education surrounding opioid addiction, overdose, and use of naloxone prior to release from correctional facilities; therefore be it

RESOLVED, That our AMA, in collaboration with state and local medical societies, support naloxone education and training programs in federal, state, and local correctional facilities in addition to distribution of naloxone free of charge to people who are incarcerated prior to release.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Disease Prevention and Health Promotion in Correctional Institutions H430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the

prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase indirect referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
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 encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

Increased Oversight of Suicide Prevention Training for Correctional Facility Staff 270.033MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 51
(I-19)

Introduced by: Region 1; Region 2; Region 3; Laura Barrera, Uniformed Services University of the Health Sciences; Keira Wilson, Northeast Ohio Medical University

Subject: Family Planning for Medical Students

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The number of women enrolled as first year medical students has recently risen to the majority of 51.6% in 2018[1]; and

Whereas, The average age of matriculated first year medical students is 24; the average amount of time specialized physicians spend in post high school training is 14 years, and the average age of mothers at first birth in the United States is 26.8 years[2-4]; and

Whereas, 9.2% of medical students are parents by graduation, and thus it is essential to address the potential of pregnancy and parenthood during the course of medical education[5];

Whereas, The rate of attrition for premedical females who ultimately attend medical school is significantly higher than expected due to social factors including policies regarding parental leave, which influence students to opt for a more accommodative career[6]; and

Whereas, There has been an increase in female physician assistant students at a rate higher than the rate of increase of female medical students, which is accounted for due to the perceived higher compatibility of maintaining a family life versus the schooling and training as a physician[7]; and

Whereas, A survey of students from the South Dakota Sanford School of Medicine shows that medical students largely want schools to provide, “clear, well-defined guidelines, scheduling flexibility and administrators who are approachable and understanding of their individual circumstances” regarding pregnancy and parenthood[5]; and

Whereas, Amongst the barriers that have been identified by female faculty physicians that prevent the advancement of qualified women in academic medicine are workplace policies that do not allow for women to maintain a balanced lifestyle in fear of not advancing in their carriers[8]; and

Whereas, A survey across 11 academic medical institutions of residents in internal medicine, family practice, pediatrics, medicine–pediatrics, surgery, and obstetrics–gynecology, found that women residents were more likely than their male counterparts to intentionally postpone pregnancy because of perceived threats to their careers[9]; and

Whereas, There is a lack of research on medical student family planning, and most research focuses on residents and physicians; and

Whereas, The Family and Medical Leave Act does not have protections for students, and thus schools are not required by law to accommodate parental leave[10]; and

Whereas, Current AMA, LCME, and COCA policy does not *require* medical schools to help medical students in family planning or lay out clear policy addressing how assignments and/or classes can be made up in a way that would be amenable to family planning, and thus many schools do not provide resources outside of individual consultation; and

Whereas, A majority of female physicians surveyed have regrets about family planning decisions and career decision-making, and if given the chance would have made decisions such as attempting conception earlier (28.6%), choosing a different specialty (17.1%), or using cryopreservation to extend fertility (7%)[11]; and

Whereas, Fewer of those medical students whose first pregnancy was in medical school perceived substantial workplace support (68.2%) than those whose first pregnancies followed training (88.6%), which points to a lack of policy and support at medical schools comparative to residency training programs[11]; and

Whereas, Female physicians have identified that clearly available policy is a barrier to career advancement[12]; and

Whereas, It is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants, indicating the necessity of alternative solutions to improve family leave in undergraduate medical education; and

Whereas, An overview addressing, “the common personal and professional challenges that medical students who are also mothers face during their undergraduate medical education” found that by addressing the challenges of breastfeeding support, lack of career advisory and support networks for parents/expecting parents, unaccommodating schedules requiring formal leaves of absence, and childcare facilitated by the institution, medical schools can support the health and promote the education of their students[13]; and

Whereas, Medical educators should be aware of educational and policy barriers when counseling female trainees and have established resources and policies; therefore be it

RESOLVED, Our AMA encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in their specific medical school including maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

RESOLVED, Our AMA collaborates with Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) to formulate comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our 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 leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental 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.
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 parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent 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 provision is 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 equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

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 parental leave and alternative schedules for pregnant house staff.
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.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Support for Family and Relationships During Medical School and Residency: 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)

Equal Paternal and Maternal Leave for Medical Residents: 310.049MSS
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 provision is 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

THIS RESOLUTION HAS BEEN WITHDRAWN TO PARTICIPATE IN THE THINK TANK SESSION

Resolution 52
(I-19)

Introduced by: Region 1; Neha Siddiqui, Carle Illinois College of Medicine

Subject: Evidence-Based Practices to Improve Maternal Mortality

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States is the only developed country in the world that reported a projected increase in maternal mortality rate from 2003-2013, despite global trends of accelerated decline[1-3]; and

Whereas, According to the CDC 53% of pregnancy related deaths in 2013 occurred on postpartum days 1-6, suggesting lack of proper monitoring and evaluation during this critical period[3-5]; and

Whereas, In 2006, in response to a rising national and state-wide maternal mortality rate, California created the California Maternal Quality Care Collaborative (CMQCC) whose primary responsibilities involved creating a state-wide maternal mortality review board and utilizing data from maternal mortality cases to develop evidence-based quality improvement toolkits[8,9]; and

Whereas, Since the creation of the CMQCC, California has seen a 55% decrease in maternal mortality from 16.9 deaths per 100,000 live births in 2006 to 7.3 deaths per 100,000 live births in 2013 while in contrast, the U.S. national maternal mortality rate continued to rise[10]; and

Whereas, Maternal morbidity has been reduced by 20.8% from 2014 to 2016 among the 126 hospitals that participated in the California Partnership for Maternal Safety, the joint hemorrhage and preeclampsia collaborative, which utilized implementation of the CMQCC's hemorrhage and preeclampsia toolkits[10]; and

Whereas, Many of these toolkits have been endorsed by the American College of Obstetricians and Gynecologists (ACOG) as a model for the development of maternal mortality safety bundles which are considered by ACOG to be evidenced-based best practices for maternity care[8]; and

Whereas, Safety bundles are collection of guidelines for best practices in evaluating and treating medical complications in the prenatal to postpartum period that have been created to combat preventable conditions that increase maternal morbidity and mortality rates[6]; and

Whereas, The evidence based practices implemented in safety bundles have been designed by the Alliance for Innovation on Maternal Health with support from the American College of Obstetricians and Gynecologists (ACOG), American College of Nurse Midwives (ACNM), Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Health Officials (ASTHO), Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), California Maternal Quality Care Collaborative (CMQCC), and the Society for Maternal-Fetal Medicine (SMFM)[7]; therefore be it

RESOLVED, That our AMA amend policy D-420.993 by addition and deletion as follows:

Disparities in Maternal Mortality, D-420.993
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; ~~and~~ (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities; and (5) will advocate for the use of evidence-based practices to improve maternal mortality rates including but not limited to: standardized monitoring protocols and safety protocols like those included in safety bundles that are endorsed and defined by ACOG and other relevant bodies.

Fiscal Note: TBD

Date Received: 09/20/2019

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9. California Maternal Quality Care Collaborative. CMQCC What We Do. https://www.cmqcc.org/about-cmqcc/what-we-do.
10. California Maternal Quality Care Collaborative. California Birth Equity Collaborative Improving Care for, by and with Black Mothers. https://www.cmqcc.org/qi-initiatives/birth-equity.

RELEVANT AMA AND AMA-MSS POLICY

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.
CSAPH Rep. 3, A-09Appended: Res. 403, A-11Appended: Res. 417, A-18

Infant Mortality D-245.994
1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparitive effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
Res. 410, A-10

State Maternal Mortality Review Committees H-60.909
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.
Res. 911, I-17

International Infant Mortality Data H-245.987
The AMA supports taking steps to make the public aware that baseline data differences exist in comparison studies, so that information presented for political purposes may be misleading.
BOT Rep. HH, A-91Reaffirmed by BOT Rep. 8, A-97Reaffirmed: CSAPH Rep. 3, A-07Modified: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 53
(I-19)

Introduced by: Kaitlyn Brown, Raveen Sugantharaj, Marian University College of Osteopathic Medicine

Subject: Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of the ACGME Single System of Accreditation

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The full implementation of the Accreditation Council of Graduate Medical Education (ACGME) single system for accreditation of graduate medical education programs in the United States allows medical school graduates of allopathic and osteopathic medical schools to complete residency and/or fellowship training in ACGME-accredited programs, eliminating the American Osteopathic Association (AOA)-approved programs[1]; and

Whereas, The number of osteopathic physicians (DOs) has increased by 54% since 2010 and projections anticipate DOs will make up 20% of the physician workforce by 2030[2]; and

Whereas, Over 70% of third year osteopathic medical students indicate their interest in applying to residency programs with osteopathic recognition[2]; and

Whereas, ACGME reports indicate that for the 2019 – 2020 academic year, there are 11,621 ACGME-accredited programs and only 221 of those programs have applied for or are already designated with osteopathic recognition, which, following formal application, designates programs with a commitment to teaching and assessing Osteopathic Principles and Practice (OPP) at the graduate medical education (GME) level[3-6]; and

Whereas, The amount of interest among allopathic residents in incorporating OPP, as well as Osteopathic Manipulative Treatment (OMT) training into GME is growing, with the most important component of an OMT curriculum considered to be the benefits to patients[7-11]; and

Whereas, "The American Osteopathic Association strongly encourages all qualified supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them"[12]; and

Whereas, Allopathic faculty at AOA/ACGME and AOA programs have concerns about their ability to precept OMT[13]; and

Whereas, Several opportunities exist for training clinicians interested in incorporating OMT into his or her practice and bolstering continuing medical education, including self-study and continuing medical education opportunities, which all can aide in advancing GME to meet the needs of future physicians, while also graduating competent physicians[14]; therefore be it

RESOLVED, That our AMA will:

1) Recommend the building of a task force in collaboration with the American Osteopathic Association, the Accreditation Council of Graduate Medical Education, the American Academy of Family Physicians, The American Academy of Osteopathic Family Physicians, and other interested parties to explore the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment; and
2) Ask the ACGME about the need for standardized education on Osteopathic Principles and Practice and Osteopathic Manipulative Treatment among faculty in ACGME-accredited programs without osteopathic recognition, in order to allow the faculty to support osteopathic residents in safely providing patient care.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

9.2.6 Continuing Medical Education
Physicians should strive to further their medical education throughout their careers, to ensure that they serve patients to the best of their abilities and live up to professional standards of excellence.
Participating in certified continuing medical education (CME) activities is critical to fulfilling this professional commitment to lifelong learning. As attendees of CME activities, physicians should:

(a) Select activities that are of high quality and are appropriate for the physician's educational needs.
(b) Choose activities that are carried out in keeping with ethics guidance and applicable professional standards.
(c) Claim only the credit commensurate with the extent of participation in the CME activity.
(d) Decline any subsidy offered by a commercial entity other than the physician's employer to compensate the physician for time spent or expenses of participating in a CME activity.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative

pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private

sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Meeting Public Health Care Needs Through Health Professions Education H-440.969
(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas.
(2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education.

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of ensuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should

be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an

assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

Focused Continuing Education Programs for Enhanced Clinical Competence H-300.980
1. The AMA encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education.
2. The AMA encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs.

3. The AMA supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development.
4. Our AMA recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice.

Continuing Medical Education for Physicians in the Hospital Setting H-300.966
It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws.

Educating Competent and Caring Health Professionals H-295.975
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 54
(I-19)

Introduced by: Akhila Padi, Bryana Baginski, University of South Carolina School of Medicine Greenville; Jasmine Landry, Albany Medical College

Subject: Buprenorphine Training in Medical Schools

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Opioid overdoses are the number one cause of accidental deaths in the United States, highlighting the need for overdose prevention and effective treatment, which should be integrated as a component of medical school curricula[1]; and

Whereas, Medication-assisted treatment (MAT), or medications to reduce opioid cravings including buprenorphine and methadone, is imperative to the long-term recovery treatment for substance use disorder (SUD)[2]; and

Whereas, Buprenorphine is an opioid partial agonist that is used in the treatment of opioid use disorder, and it is effective in managing withdrawal symptoms and reducing the potential for relapse[2]; and

Whereas, Buprenorphine can be prescribed in various settings including primary care offices, emergency departments, SUD clinics, and hospitals, while other MAT options such as methadone can only be prescribed at certified facilities[3]; and

Whereas, Office-based buprenorphine treatment is correlated with reduced illicit opioid use compared to traditional inpatient detox[4]; and

Whereas, Because buprenorphine can be prescribed in multiple settings, increasing buprenorphine prescribers have increased patient access to MAT in counties that previously had few MAT options[5]; and

Whereas, The two largest barriers to buprenorphine use in the treatment of SUD are cost to the patient and system-wide provider capacity to prescribe buprenorphine in MAT[6]; and

Whereas, State implementation of the Medicaid expansions were associated with a 70% increase in Medicaid-covered buprenorphine prescriptions, and a 50% increase in Medicaid spending on buprenorphine[6]; and

Whereas, Buprenorphine can only be prescribed by provider with a valid medical license, valid DEA registration to prescribe controlled substances, and a DEA waiver earned by 8 hours of additional qualifying training[7]; and

Whereas, Under 7% of the physicians in the US currently have a DEA waiver to prescribe buprenorphine[8]; and

Whereas, More than half of the counties in the US lack even one physician who can prescribe buprenorphine[8]; and

Whereas, Out of the physicians that do have the waiver, less than half offer the treatment to their patients[9]; and

Whereas, These reasons may be multifaceted, and can include stigma regarding OUD amongst physicians[9]; and

Whereas, The AMA voted not to support the elimination of the DEA waiver requirement for prescribing buprenorphine[10]; and

Whereas, Current AMA policy encourages the expansion of residency and fellowship opportunities in the treatment of opioid use disorders, but does not include medical students; and

Whereas, AMA resolution H-95.922 states AMA will "renew efforts to have substance use disorders addressed across the continuum of medical education," which may include education on medication-assisted treatment such as buprenorphine; and

Whereas, Multiple medical schools in the country have made it a focus to implement a curriculum that focuses on completing the DEA waiver requirements so that medical students are more educated, knowledgeable, and prepared to care for patients with opioid use disorder after graduation[11]; and

Whereas, The SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act of 2018 allows any physician who graduates from an accredited medical school that "incorporates necessary material around opioid misuse in their standard curriculum, without the need for any additional training, to prescribe buprenorphine"[12]; and

Whereas, Among physicians with a DEA waiver to prescribe buprenorphine, physicians who work in a practice with another waivered provider are significantly more likely to prescribe buprenorphine, highlighting the need to increase the number of waivered providers[13]; and

Whereas, Buprenorphine training into medical school curriculum will reduce the shortage of providers that can provide buprenorphine, reduce barriers that patients find in finding prescribers, as well as help remove the stigma from treatment by increasing physician knowledge; therefore be it

RESOLVED, That our AMA strongly encourage a standardized buprenorphine training addition into medical school curriculum to reduce the patient-provider gap in prescribing medication-assisted treatment to those with substance use disorder.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

D-120.985: Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:
"1) Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice. 2) Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management. 3) Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association,

Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians."

H-310.906: Improving Residency Training in the Treatment of Opioid Dependence: " Our AMA:
(1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders."

D-95.972: Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder:
"1) Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder. 2) Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder."

H-95.922: Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

THIS RESOLUTION HAS BEEN WITHDRAWN TO PARTICIPATE IN THE THINK TANK SESSION

Resolution 55
(I-19)

Introduced by: Region 1; Saima Wase, Northeast Ohio Medical University

Subject: Protecting Immigrant Health and Well-Being

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, In 2017, 22 million noncitizens, including lawfully present and undocumented immigrants, were residing in the United States, which accounted for about 7% of the total U.S. population[1]; and

Whereas, Among the nonelderly population, 23% of lawfully present immigrants and 45% undocumented immigrants are uninsured compared to 8% of citizens, creating concerns that immigrant health needs are inadequately being addressed[1]; and

Whereas, The majority of states in the U.S. do not extend healthcare benefit options to undocumented immigrants yet several recent analyses demonstrate significant cost savings associated with expanding healthcare access to undocumented immigrants[1-7]; and

Whereas, Between January 1, 2016 and September 30, 2017, U.S. Immigration and Customs Enforcement (ICE) removed 61,000 immigrants and arrested 110,00 people, representing a 37% increase in immigrant removals and a 42% increase in arrests from an equivalent period in the previous year[8]; and

Whereas, Research reveals these recent efforts to enhance immigration enforcement and restrict immigration have substantially increased fears among the immigrant community causing many families to turn away from previously used healthcare programs and services, including Medicaid and CHIP[9]; and

Whereas, The U.S. Supreme Court upheld a July 2019 executive order changing the definition of who can qualify for refugee status to limit the entry of migrants into the U.S., demonstrating the susceptibility of migrant classifications to arbitrary change and the ensuing changes in benefit qualification including healthcare benefits[10]; and

Whereas, As of August 2019, an average of 55,530 individuals were reported to be detained by ICE on any given day, up from an average of 34,000 detainees per day between 2008 and 2016[11]; and

Whereas, From October of 2003 through 2015, there have been 154 total immigrant deaths in ICE custody[12]; and

Whereas, Of 52 deaths since March 2010 that have occurred in U.S. immigration detention centers that have been evaluated by government or outside experts, 23 (42%) were linked to substandard care[13]; and

Whereas, From 2004 through 2015 there had been a general decrease in the number of in-custody immigrant deaths reported each year corresponding to improvements in ICE medical policies and practices (one policy revision occurring in 2008 and another in 2011) with an average of eight in-custody immigrant deaths per year from 2008 through 2015[12,14]; and

Whereas, In just the last 2.5 years, twenty-four immigrants have died in ICE custody (with one more dying shortly after being sent to the hospital and officially labeled as paroled by ICE) and seven children have died in U.S. custody after being detained by ICE and/or CBP following over a decade with zero child deaths in or shortly following ICE and CBP detention[15-17]; and

Whereas, A 2018 report published by the Human Rights Watch working with independent medical experts to review government records pertaining to deaths in U.S. immigration detention from late 2015 to mid-2017 found that in 8 of the 15 cases (53%) reviewed poor medical care contributed to or led to deaths[13]; and

Whereas, In January 2019 the Department of Homeland Security (DHS) Office of the Inspector General inspected ICE's contracted detention facilities and found 14,000 health and safety deficiencies mainly related to physical and mental healthcare procedures for detainees[18]; and

Whereas, In December 2017, following Executive Order 13767, ICE reversed a prior policy banning detainment of pregnant women[19,20]; and

Whereas, Since this change in policy, testimonies from detained pregnant women have alleged inadequate access to prenatal care[21]; and

Whereas, A medical record review conducted by ICE found the rate of detainees suffering a miscarriage has doubled since 2017 with many of these occurring in the second trimester[21,22]; and

Whereas, The American Academy of Pediatrics has deemed all ICE detention centers unfit for children and advocates for all migrant children, regardless of immigration status, to have access to proper medical services[23]; and

Whereas, The Flores Settlement Agreement, determined in *Flores v Reno*, requires that children under the care of DHS must be housed in the "least restrictive setting appropriate to the child's age and special needs, provide notice of rights, safe and sanitary facilities, toilets and sinks, drinking water and food, medical assistance, temperature control, supervision, and contact with family members," which the AAP has also determined is not being achieved[23,24]; and

Whereas, Reports have come out detailing that immigrants, including children, have often been held by U.S. Customs and Border Patrol (CBP) and ICE in short-term detention facilities for days to months in cramped cells, sometimes without being given enough food and water and sometimes with no access to soap, toothpaste, clean diapers for infants, or places to wash their hands or shower[25-28]; and

Whereas, Some reports have emerged of children sleeping on concrete floors in extreme cold and adults having to stand for days due to lack of space[25]; and

Whereas, There have been outbreaks of flu, lice, chicken pox, and scabies within immigrant detention facilities[29,30]; and

Whereas, U.S. Immigration and Customs Enforcement has internal policy 4.3 that states ICE should ensure "access to appropriate and necessary medical, dental and mental health care, including emergency services"[31]; and

Whereas, Despite ICE's internal policies supporting appropriate healthcare access for immigrant detainees, immigration authorities have been blocking independent physicians and medical personnel interested in providing healthcare for immigrants and refugees from entering detention centers[32]; and

Whereas, Due to inadequate healthcare available at migrant detention centers, ill detainees may receive healthcare at off-site hospitals, but their medical problems tend to persist when they re-enter crowded detention facilities[33]; and

Whereas, In June 2019, the Center for Human Rights & Constitutional Law and co-counsel filed a motion asking for independent doctors to be allowed immediate access to assess and triage children's medical needs and to allow public health experts to inspect facilities and determine how to make them safe and sanitary in accordance with the Flores Settlement[32]; therefore be it

RESOLVED, That our AMA will call for access for independent medical personnel to any U.S. Customs and Immigration Enforcement and U.S. Customs and Border Patrol detention centers housing undocumented immigrants and refugees to ensure they are provided adequate medically-necessitated care, and advocate for experience-level-appropriate medical training of the personnel charged with the care of undocumented immigrants and refugees within these centers; and be it further

RESOLVED, That our AMA amend policy H-350.957 Addressing Immigrant Health Disparities by addition and deletion as follows:

1. Our American Medical Association recognizes the unique health needs of undocumented immigrants and refugees and encourages the exploration of issues related to undocumented immigrants and refugee health and support legislation and policies that address the unique health needs of undocumented immigrants and refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrants, including children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for immigrants, regardless of legal status, and asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation ~~for asylum~~ at or entry into the United States regardless of country of origin.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. Res. 017, A-17

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. Res. 254, A-18

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations 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. Res. 013, A-19

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. Res. 018, A-17

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

Improving Medical Care in Immigration Detention Centers 350.016MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations 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. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. MSS Res 22, A-17, Immediate Transmittal; AMA Res 017, A17 Adopted as Amended [D-350.983]

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS
(1) That our AMA 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 (2) That our AMA amend AMA policy H-20.901 by addition and deletion to read as follows:
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. (3) That this resolution be forwarded immediately to the House of Delegates at A-18. MSS Res 01, A-18

Increasing Access to Healthcare Insurance for Refugees 250.028MSS
AMA-MSS will ask that our AMA support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in healthcare for refugees. MSS Res 05, I16; AMA Res 006, A-17 Adopted [H-350.956]

Opposing the Office of Refugee Resettlement's use of Medical Psychiatric Records for Evidence in Immigration Court 250.030MSS
That our AMA advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children (2) That our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. MSS Res 15, I-18

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask that our AMA-MSS Digest of Policy Actions/ 94 350.016MSS 350.017MSS 350.018MSS AMA 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]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 56
(I-19)

Introduced by: Region 3

Subject: Support for Assisted Outpatient Treatment

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, "Assisted outpatient treatment" (AOT), also known as mandated outpatient treatment (MOT) and community treatment orders (CTOs), is a state and local legal mechanism that help individuals with serious mental illness receive psychiatric treatment[1-2]; and

Whereas, AOT connects individuals with mental illness, a history of psychiatric crises or hospitalizations, and likelihood of poor treatment adherence, to comply with a legally mandated outpatient psychiatric treatment regimen, in an attempt to improve these individuals' quality of life and integration into their community[1-2]; and

Whereas, The Protecting Access to Medicare Act of 2014 (PAMA), which established an AOT grant program funded by the US Substance Abuse & Mental Health Services Administration (SAMHSA), defines AOT as "medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a state or local court to order such treatment"[3]; and

Whereas, AOT is endorsed by many national organizations, including the American Psychiatric Association, the US Substance Abuse & Mental Health Services Administration, and the US Department of Justice[4-6]; and

Whereas, The National Institute of Corrections states that AOT "should be used more to assure [that] released prisoners receive and take properly prescribed medications," as these individuals are otherwise three times more likely to be found in jails or prisons than in mental healthcare[7]; and

Whereas, AOT can increase treatment adherence and reduce psychiatric symptoms, psychiatric hospitalization, and some forms of interpersonal violence[8-12]; and

Whereas, AOT can reduce the average cost of mental health treatment, medical treatment, and criminal justice services by up to 57% on average within the first twelve months of enrollment in the program[13]; and

Whereas, 47 states have laws allowing AOT, but not all counties and localities have AOT programs,[5,14] meaning that this mechanism may be unavailable or inaccessible for individuals in these areas; and

Whereas, Many AOT programs are supported by public funds, such as the US Substance Abuse and Mental Health Services Administration,[3,14] and therefore the role of organizations such as the AMA in collaborating with federal, state, and local policymakers can be important in maintaining financial support for AOT programs; and

Whereas, Our AMA has previously passed policy to align with the American Psychiatric Association's opinions on other issues in psychiatry that might require federal, state, or local support and funding,[15,16] similar to AOT's dependence on support from policymakers; therefore be it

RESOLVED, That our AMA supports the use of assisted outpatient treatment as a method of intervention for individuals with serious mental illness at the state and local level in the United States.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services. Res 116, A-12; Reaff: A-15

Prevention of Impaired Driving H-30.936
Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace

other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life; CCB/CLRPD Rep 3, A-14

E-9.7.2 Court-Initiated Medical Treatments in Criminal Cases
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.
In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician’s diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given. AMA Principles of Medical Ethics: I, III; Issued: 2016; Mod: 2017.

E 2.1.2 Decisions for Adults Who Lack Capacity
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient’s decision-making capacity. Even when a medical condition or disorder impairs a patient’s decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

(a) Identify an appropriate surrogate to make decisions on the patient’s behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or

(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.

(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.

(c) Provide advice, guidance, and support to the surrogate.

(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:

(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;

(ii) the patient's views about life and how it should be lived;

(iii) how the patient constructed his or her life story; and

(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.

(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:

(i) the pain and suffering associated with the intervention;

(ii) the degree of and potential for benefit;

(iii) impairments that may result from the intervention;

(iv) quality of life as experienced by the patient.

(f) Consult an ethics committee or other institutional resource when:

(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;

(ii) ongoing disagreement about a treatment decision cannot be resolved; or

(iii) the physician judges that the surrogate's decision:

a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;

b. could not reasonably be judged to be in the patient's best interest; or

c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics I, III, VIII; Issued: 2016; Mod: 2017

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 57
(I-19)

Introduced by:	Region 3; Region 5; Richard Saporito, Rutgers New Jersey Medical School; Jacob Radparvar, Tufts University School of Medicine; Matthew Van De Graaf, Eastern Virginia Medical School, Alex Butler, Columbia University Irving Medical Center; Samuel Roberts, Midwestern University
Subject:	Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing
Referred to:	MSS Reference Committee (Pauline Huynh, Chair)

Whereas, Direct-to-Consumer genetic tests are products available for purchase by the public from testing companies in which consumers send in a sample of their DNA and companies generate a report of predictions on user health, ancestry, and common traits by using genetic variation data[1]; and

Whereas, Direct-to-Consumer genetic tests are increasing in popularity in the United States with more than 26 million users by early 2019 and a projected 100 million by 2021[1]; and

Whereas, Direct-to-Consumer genetic tests are often unreliable due to: (1) reliance on non-validated algorithms and single nucleotide polymorphisms that may over or under-predict risk of disease[2], (2) failing to fully represent the multifactorial nature and variation in etiology of diseases[3], and (3) underrepresentation of populations not classically studied in epidemiologic studies with 90% of subjects in genome-wide association studies having European ancestry[4,5]; and

Whereas, Results from Direct-to-Consumer genetic tests can be used by consumers to inform their healthcare decisions in lieu of consulting medical professionals[6]; and

Whereas, While some companies offering Direct-to-Consumer genetic tests provide genetic counseling for an additional fee, there is little to no guidance, explanation or interpretation of these results to consumers[6]; and

Whereas, Physicians must be prepared to educate patients on the health benefits and risks of these tests to ensure overall patient well being and safety[7]; and

Whereas, The FDA recognizes that direct-to-consumer genetic tests can be unreliable and may persuade patients to undergo unnecessary health procedures[8]; and

Whereas, Unauthorized access to results from personal genetic information can result in unintended consequences without patient consent including, but not limited to, employer discrimination against employees, genetic information being used for state surveillance, and genetic information being used to influence decisions[1]; and

Whereas, Genetic information generated from Direct-to-Consumer genetic tests can be sold to third-party companies without customer knowledge or consent[6], and can be released on court

order to law enforcement and other agencies, leading to the criminal charging of customers and/or their relatives[9]; and

Whereas, The Genetic Information Nondiscrimination Act (GINA) does not apply to disability insurance, life insurance, employees of companies with 15 or fewer employees, or active U.S. military or veterans, and thus genetic information from Direct-to-Consumer genetic tests can be accessed and used in the consideration of risk assessment by insurance companies[10]; and

Whereas, HIPAA does not apply to these Direct-to-Consumer genetic testing companies[11]; and

Whereas, There are ethical concerns about pediatric consent in Direct-to-Consumer genetic testing and ownership of a child's genetic information[6]; and

Whereas, Genetic testing of asymptomatic children is contraindicated within the healthcare industry as there must be therapeutic or preventive measures available in the case of a genetic predisposition to adult-onset diseases, and Direct-to-Consumer genetic testing companies bypass this standard[12]; therefore be it

RESOLVED, That our AMA address Direct-to-Consumer genetic testing by amending H-460.908, "Genomic-Based Personalized Medicine," by insertion as follows:

Genomic-Based Personalized Medicine, H-460.908

(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~~.~~; and (4) will develop a guideline on how physicians should engage with patients who are pursuing genetic testing outside of the medical setting.
; and be it further

RESOLVED, That our AMA amend D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing," by insertion and deletion as follows:

Direct-to-Consumer Marketing and Availability of Genetic Testing, D-480.987

[...] (5) will work to educate and inform physicians and patients regarding the ~~types~~ benefits and risks of genetic tests that are available directly to consumers, including, but not limited to information about the lack of scientific validity associated with some direct-to-consumer genetic tests, privacy violations, and company ownership of patient data; ~~so that patients can be appropriately counseled on the potential harms.~~
; and be it further

RESOLVED, That our AMA-MSS amend 200.019MSS, "Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems," by insertion as follows:

Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems, 200.019MSS

[…] (2) , That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts; 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.

; and be it further

RESOLVED, That our AMA support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Genetic Testing & Counseling E-4.1.1
Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others. Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient's care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological implications for the individual's biological relatives; (iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and (iv)that the physician will be available to assist in communicating with relatives. (d) Obtain the individual's informed consent for the specific test or tests to be performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information.

Genetic Testing for Reproductive Decision Making E-4.1.2
Genetic testing can provide information to help prospective parents make informed decisions about childbearing. Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse ancestries becomes more common and tests for more conditions become more accurate and less costly, the relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians may ethically provide genetic testing to inform reproductive decision making when the patient requests, but may also wish to offer broad screening to all persons who are considering having a child. Physicians who provide reproductive health care that includes genetic testing should: (a) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (b) Discuss reasons for and against genetic testing and ethically inappropriate uses of genetic testing, such as to identify non-disease-related characteristics or traits. (c) Obtain the individual's informed consent to the specific test or tests to be performed. Physicians should

ascertain whether the person wishes to be informed about incidental findings. (d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors relevant to a decision about childbearing. (e) Respect an individual's decision to terminate or continue a pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. (f) Refer the individual to another qualified physician when personal moral values prohibit the physician from providing lawful abortion services when this is a service that the person desires, in keeping with ethics guidance.

Improving Genetic Testing and Counseling Services H-480.944
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.

Confidentiality of Computerized Patient Records H-315.989
The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.

Direct-to-Consumer Marketing and Availability of Genetic Testing D-480.987
(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.

Third-Party Access to Genetic Information 4.1.3
The rapid pace of development and dissemination of genetic testing has made it possible to generate information about individuals across a wide and growing spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual's health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information. Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual. Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to: (a) Maintain the confidentiality of the patient's health information, including genetic information. (b) Release a patient's genetic information to third

parties only with the patient's informed consent. (c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient's request and with their informed consent.

Genetic Susceptibility Testing for Hereditary Cancers H-55.979
(1) That physicians who feel unprepared to provide comprehensive genetic test counseling should refer candidates for genetic susceptibility testing to specialized care centers with experience and expertise in hereditary cancers or to investigators for relevant research, where family history can be confirmed and they can be tested if they so choose. (2) That genetic susceptibility testing, including that marketed directly to consumers, should be provided only in the context of fully informed consent and comprehensive pre- and post-test counseling by a qualified health care professional.

Genomic-Based Personalized Medicine H-460.908
(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.

Genetics Testing Legislation H-460.931
The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing.

Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems 200.019MSS
[…] (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.

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred

practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the

public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Genomic and Molecular-based Personalized Health Care D-460.976
(1) continue to recognize the need for possible adaptation of the US 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 US health care system; (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing; (4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and (5) promote the appropriate use of pharmacogenomics in drug development and clinical trials.

Direct-to-Consumer Laboratory Testing H-480.941
Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

Informed Consent in Research E-7.1.2
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will. Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary. A valid consent process includes: (a) Ascertaining that the individual has decision-making capacity. (b) Reviewing the process and any materials to ensure that it is understandable to the study population. (c) Disclosing: (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research; (ii) any conflicts of interest relating to the research, in keeping with ethics guidance; (iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience; (iv) the likelihood of therapeutic or other direct benefit for the participant; (v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study; (vi) the nature of the research plan and implications for the participant; (vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician. (d) Answering questions the prospective participant has. (e) Refraining from persuading the individual to enroll. (f) Avoiding encouraging unrealistic expectations. (g) Documenting the individual's voluntary consent to participate. Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when: (h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research. (i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity. (j) There is potential for the individual to benefit from the study. In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 58
(I-19)

Introduced by: Student National Medical Association; Sally Midani, University of New Mexico School of Medicine; Avi Levy, Midwestern University Arizona College of Osteopathic Medicine; Shradha Biradar, Camilo Pardo, Tuoro University College of Osteopathic Medicine; Nikhil Datla, Northeast Ohio Medical University

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical treatment to their country of origin by healthcare professionals[1]; and

Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign country, provoking an unwarranted intersection between immigration enforcement and the healthcare system[2]; and

Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017, a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall healthcare spending in a population with the highest risk of being uninsured among the non-elderly population[2-4]; and

Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally funded health institutions with emergency care capabilities are mandated to treat all patients with emergent medical conditions who present to their facility until deemed stable, regardless of their insurance coverage or financial status[5]; and

Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-term care alternative is available to the patient as a cost-saving mechanism[6]; and

Whereas, Care centers like St. Joseph’s Hospital and Medical Center in Phoenix, Arizona partake in forced medical repatriation for undocumented immigrant patients and a Florida patient experienced involuntary deportation prior to the completion of their appeal or asylum verdict[7-9]; and

Whereas, Forced medical repatriation has led to serious medical consequences for patients, exacerbating the severity of existing medical conditions[10,11]; and

Whereas, Patients experienced a lapse and deterioration of care due to the inability of the patient's country of origin to provide adequate treatment and concurrent separation from their community in the U.S. during a time which may require emotional, physical and financial support[6,7,9,12]; and

Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical consequences related to repatriation[7,13]; and

Whereas, Forced medical repatriation increases health disparities among migrant communities and deters immigrants from seeking necessary medical services[14,15];and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care[16,17]; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum[18]; and

Whereas, The AMA Journal of Ethics encourages health care systems to seek routes of care to avoid forced medical repatriation and the AMA Code of Ethics Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations" [2,19,20]; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)[21,22]; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation[7,23]; therefore be it

RESOLVED, That our AMA ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers; and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation and acknowledge the ethical standards of the medical profession; and be it further

RESOLVED, H-350.957 be amended as follows:

Addressing Immigrant Health Disparities

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. 3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. 4. Our AMA discourage the practice of forced medical repatriation if a patient has a right to an appeals process.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Limit Scope of EMTALA to Original Legislative Intent D-130.994
(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.
(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.
(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.

EMTALA -- Major Regulatory and Legislative Developments D-130.982
Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.
2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions; (2) make the PRO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call specialist, including

situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Repeal of COBRA Anti-Physician Provisions H-130.959
It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.

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.

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask that our AMA 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])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 59
(I-19)

Introduced by: Haritha Pavuluri, Tristan Mackey, Maggie Oliver, University of South Carolina School of Medicine Greenville

Subject: Incorporating the Choosing Wisely Program into Undergraduate and Graduate Medical Education

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States healthcare system is the most expensive in the world and produces worse outcomes than comparable lower-cost health systems[1]; and

Whereas, A 2014 national survey of 600 physicians found that nearly three-quarters of them believe unnecessary tests and procedures represent a serious problem in the health care system,[7]; and

Whereas, Studies have shown that physicians whose residencies were in higher-spending regions spent 29% more on average on medical care for their patients than their peers who had trained in lower-spending areas of the country[2]; and

Whereas, The increased spending on medical care was shown to persist even if the new physicians went to another region of the country with lower health care spending, and mean spending for physicians trained in residency programs with higher-cost patient care averaged $522 more per Medicare patient each year[2]; and

Whereas, These higher-cost practice traits persisted until they appeared to level off at mid-career, around 16 to 19 years after residency, suggesting that interventions during residency training may have the potential to help control future health care spending[2]; and

Whereas, The Choosing Wisely campaign is an international campaign developed by physicians and for physicians, with the primary aim of providing care that is “supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary”[6]; and

Whereas, A 2014 survey of 600 physicians found that physicians with exposure to the Choosing Wisely Campaign were 17 points more likely to have reduced the number of tests or procedures they have done in the last 12 months[7]; and

Whereas, Following Choosing Wisely recommendations in infectious disease treatment would reduce potential harm to patients and increase the value of health care when implementing these recommendations[3]; and

Whereas, Choosing Wisely recommendations serve to improve quality and optimize both clinical outcomes and resource utilization in newborn care[4]; and

Whereas, Implementation of a Choosing Wisely campaign across 25 medical offices serving approximately 300,000 members led to a sustained reduction in non-beneficial services in ambulatory care, including reduced use of complete blood counts (CBCs) and electrocardiograms (EKGs) as routine screening tests in physical examination visits, age-inappropriate dual-energy x-ray absorptiometry (DEXA) scans, and imaging for uncomplicated headache[8]; and

Whereas, Choosing Wisely recommendations facilitate prudent care decisions, reducing unnecessary health care spending and preventing harm in the field of nephrology[5]; and

Whereas, A quality initiative based on Choosing Wisely recommendations implemented in three internal medicine residencies led to a 50% decrease in median blood test count, a decrease in median length of hospital stay, and decreased percentage of patients requiring transfusions[9]; and

Whereas, A high value care curriculum for interns in an internal medicine residency program, consisting of six seminars based on sources including the Choosing Wisely campaign, was rated as highly useful by interns (mean score 4.4/5) with a significant improvement in their self-rated knowledge, skills, and attitudes regarding high value patient care[10]; and

Whereas, A 45-minute morning report on high value care delivered to academic internal medicine trainees was described as educationally valuable by 96% of attendees, and resulted in a significant increase in the trainees' self-reported understanding of the cost for diagnostic tests and in the likelihood that costs of diagnostic tests would affect their future ordering practices[11]; and

Whereas, Incorporation of evidence-based imaging curriculum using the American College of Radiology (ACR) Appropriateness Criteria (which overlap with Choosing Wisely recommendations from ACR) into a radiology clerkship found that a majority of medical students were unaware of this resource prior to the educational sessions, and 89% reported a solid understanding of indications for imaging tests and a likelihood of using them in future practice after the sessions[12]; and

Whereas, Our AMA currently supports the concepts of the Choosing Wisely program (AMA Policy D-155.988); and

Whereas, Our AMA supports choosing the course of action that requires fewer resources with similar likelihood and degree of anticipated benefit, and that physicians have the training they need to be informed about health care costs (Physician Stewardship of Health Care Resources 11.1.2); and

Whereas, Our AMA supports value-based health care, and cost reduction, but has no policy on the importance of including this in medical education (Physician Stewardship of Health Care Resources 11.1.2); therefore be it

RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the "Choosing Wisely" Program by insertion as follows:

Support for the concepts of the "Choosing Wisely" Program, D-155.988

1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

2. Our AMA supports the incorporation of the American Board of Internal Medicine Foundation's Choosing Wisely program concepts and initiatives into undergraduate and graduate medical education.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Support for the Concepts of the Choosing Wisely Program D-155.988
Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

Physician Stewardship of Health Care Resources 11.1.2
Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the

shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.
To fulfill their obligation to be prudent stewards of health care resources, physicians should:
(a) Base recommendations and decisions on patients' medical needs.
(b) Use scientifically grounded evidence to inform professional decisions when available.
(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.
(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.
Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:
(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.
(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
(2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and
(3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

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)

295.177MSS: 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, I13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 60
(I-19)

Introduced by: Region 2; Region 3

Subject: Increases in government funding of programs that teach social education and housing maintenance skills for those with mental health problems as a means to assist eradicating homelessness and improve outcomes

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, In 2018, there were an estimated 553,000 homeless people in the United States[1]; and

Whereas, That same year, 111,122 homeless people had a serious mental illness[2]; and

Whereas, One of the strongest predictive factors of becoming homeless is having a serious mental illness[3]; and

Whereas, Homelessness leads to an increase in incarceration rates for those with mental illnesses and has been associated with increased rates of suicide[4]; and

Whereas, Persons with severe mental illnesses have difficulty maintaining housing in programs such as permanent supportive housing[3, 5] ; and

Whereas, This is often due to their inability to navigate daily living due to lack of social skills that would allow them to live independently with success[3, 5]; and

Whereas, Social skills in this context can be defined as, tenant-landlord relationships[3], money management[3,5], expressive, receptive, conversational, and assertive communication.[5,6]; and

Whereas, Interventions most likely to improve the quality of life of homeless persons with mental illness include those that teach skills to maintain stable housing[7]; and

Whereas, Modified therapeutic communities (MTC) utilize goal oriented daily regimens from staff who stress personal responsibility with the use of personal and professional support[8]; and

Whereas, MTC showed improved outcomes in patients through decreased substance abuse, criminal behavior, and depression through teaching social skills required for independent living and vocational development[8]; and

Whereas, Patients who are successful within MTC are recruited as peer counselors[8] which is key to success, as peer support systems have been shown to improve housing outcomes[9]; and

Whereas, Current AMA policy advocates broadly for access to care and program development for homeless persons with mental illness, however current policy does not advocate for programs that assist persons in maintaining housing through teaching proper social skills shown to improve patient outcomes; therefore be it

RESOLVED, That H-160.978 The Mentally Ill Homeless be amended by insertion:

H-160.978 The Mentally Ill Homeless
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multi-problem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. (4) The AMA encourages the use of programs focused on providing the mentally ill with the skill sets required for maintaining stable housing (e.g., social skills, interpersonal skills, vocational skills, and personal responsibility).

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

H-160.978 The Mentally Ill Homeless
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multi-problem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

H-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.

H-160.903 Eradicating Homelessness
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

H-345.975 Maintaining Mental Health Services by States
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and

5. will take these resolves into consideration when developing policy on essential benefit services.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 61
(I-19)

Introduced by: Region 2; Student National Medical Association; Dylan Kirschenbaum, Akhil Uppalapati, Max Goder-Reiser, Boston University School of Medicine; Andrew Stephenson, University of Cincinnati School of Medicine; Neal Nathan, University of Southern California Keck School of Medicine

Subject: AMA Funding of Political Candidates Who Oppose Research-Backed Firearm Regulations

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Given the 100,120 reported firearm injuries and 36,383 reported firearm deaths in the United States each year on average and the significant financial burden that the gun violence epidemic poses on society, the AMA recognizes that gun violence represents a public health crisis in our country (D-145.995)[1-3]; and

Whereas, Laws that required a heightened showing of suitability for concealed carry, such as universal background checks and "may issue" laws, and laws that prohibit gun possession by people convicted of violent misdemeanors, were found to be associated with lower firearm homicide rates[4]; and

Whereas, The AMA has adopted several policies demonstrating support for increased regulation of firearm sales as well as research into the efficacy of different regulations (H-145.997, H-145.975, H-145.972, H-145.996, H-145.985)[5]; and

Whereas, The Dickey Amendment currently prevents the Centers for Disease Control and Prevention from using funding to advocate for and promote gun control, but does not place an explicit ban on gun violence research[7]; and

Whereas, The AMA political action committee continues to make donations to politicians who vote in opposition to aforementioned firearm regulation policies, donating $54,889 combined to 17 candidates in 2018 who were also financed by the National Rifle Association and received A-ratings from the National Rifle Association [6,8-9]; and

Whereas, political ratings are used to measure a politician's alignment with the mission of the National Rifle Association and overall support for firearm regulation[9,10]; and

Whereas, 141 Congress members received donations from both physician organization PACs and the NRA PVF in 2018, and with one exception, sitting NRA-backed congress members who received funds from physician organizations voted on policies not in keeping with physician recommendations, including opposing legislation to require universal background checks, and to prevent individuals prohibited from owning a firearm from utilizing shooting ranges[8,10]; and

Whereas, The National Rifle Association Institute for Legislative Action denies the existence of the "gun show loophole," opposes expanding firearm background check systems, and opposes firearm registration, contradicting AMA policy supporting expansion of background checks and registration of firearms (H-145.996)[11]; and

Whereas, The AMA has called upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries (G-640.020); and

Whereas, The AMA-MSS urges regional delegates to recruit physicians and students for both the AMPAC as well as individual state political action committees (565.003MSS), but when the political action committees do not represent the voice of physicians and physicians in training it presents a challenge to this recruitment; therefore be it

RESOLVED, That our AMA amend policy D-145.995 as follows:

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~~ remove any barriers to gun violence research and to allow the Centers for Disease Control and Prevention to advocate for and promote firearm regulation.
;and be it further

RESOLVED, That our AMA amend policy G-640.020 as follows:

Political Action Committees and Contributions G-640.020
Our AMA:
(1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;

(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;

(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;

~~(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;~~

(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;

(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;

(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and

(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.

(9) Calls upon all candidates for public office to refuse contributions from the National Rifle Association and their subsidiaries, as well as any organization that opposes legislation enacting research-based firearm regulations.

;and be it further

RESOLVED, That our AMA discontinue donations to political candidates that vote against gun violence reform supported by AMA policies.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS 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.

Political Action Committees and Contributions G-640.020
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;
(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;
(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;
(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;
(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;
(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;
(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and
(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. 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:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) 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;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) 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;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) 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
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or

import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Building AMA-MSS Membership through Promotion of AMPAC and State Medical PACs 565.003MSS:
(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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 62
(I-19)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville

Subject: Mitigating the Effects of the Opioid Epidemic on the Foster Care System

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Based on the latest data from 2017, there were 70,237 opioid overdose deaths in the United States, which represents a 9.6% increase from 2016[1]; and

Whereas, From 1999 to 2017, more than 700,000 people have died from a drug overdose[1]; and

Whereas, The foster care system saw a 30% decline in the number of children entering the system from 1999 to 2012, but the number rose nationally by 7% from 2012-2016[2]; and

Whereas, Six states saw their foster care populations rise by more than 50 percent over this same four-year period[3]; and

Whereas, The states with the 5 highest rates of additions to the foster care system also have opioid mortality rates well above the national average[2]; and

Whereas, In the average county nationwide, a 10 percent increase in the overdose death rate corresponded to a 4.4 percent increase in the foster care entry rate[4]; and

Whereas, The number of children under the age of 1 represents the highest percentage by age group entering the foster care system, with an increase from 39,697 to 50,076 children from 2011 to 2017[5]; and

Whereas, Between 2000 and 2017 nearly 1.2 million foster care entries had parental drug use as the primary cause of entry, which correlates to an increase in foster care placement attributable to parental drug use from around 15% in 2000 to 36% in 2017[6]; and

Whereas, The cost of caring for a foster child is approximately $19,000 per child per year[2]; and

Whereas, The practice of assessing substance use in child welfare cases is extremely inconsistent and in many places inadequate to successfully identify the extent of substance use[4]; and

Whereas, Substance use by itself may not be a sufficient reason to remove children from the home, and therefore represents the need for each family's situation to be uniquely assessed[4]; and

Whereas, Parental opioid use often leads to impaired development and increases in adverse childhood experiences due to factors included but not limited to attachment issues and extended separation from parents[7]; and

Whereas, A parent's substance use disorder [SUD] is often not treated immediately upon a child's removal and often lags behind the foster care placement decision[4]; and

Whereas, Stigma, misunderstanding, and mistrust still exist in regard to medication-assisted treatment (MAT), especially in the child welfare field, which often leads to judges and child welfare programs not considering the use of MAT in the process of a child's removal[4]; and

Whereas, There are often barriers and differences between state agencies' approaches to SUD, especially in regard to its criminalization, treatment, and the specific role of MAT when addressing SUD [4]; and

Whereas, Parents using substances have a wide array of interrelated issues and needs, which represents the need for unique approaches to supporting the recovery of these parents and ensuring their child's safety and well-being[4]; and

Whereas, The standards for when a child can be reunited with a parent with a substance use disorder still remains inconsistent and is not well-defined[4]; and

Whereas, There continues to be a lack of appropriate resources such as family-friendly treatment options, an appropriate number of child welfare caseworkers, and foster homes in most communities, especially those most affected by substance use disorder[4]; and

Whereas, As of 2019, state welfare agencies have the ability to receive partial federal reimbursement for time-limited substance use, mental health, and parental training services provided to families with a child at risk for entering foster care[7]; and

Whereas, Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care (AMA Policy H-60.910); therefore be it

RESOLVED, That our AMA recognize the increased burden that the opioid epidemic has placed on the foster care system; and be it further

RESOLVED, That our AMA support adaptations, such as increased funding and legislative changes, to the foster care system to ensure the physical, mental, and emotional wellbeing of children impacted by the opioid epidemic.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.

2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state-based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's-controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state based PDMPs.

Addressing Foster Care Healthcare Needs 440.062MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 63
(I-19)

Introduced by: Region 3; Abdoulie Njai, Calli Morris, University of Missouri School of Medicine; Rachel Safeek, Jerome Soldo, University of Louisville School of Medicine; Joseph Whelihan, University of Florida College of Medicine; Nicholas Joseph, Harvard Medical School

Subject: Addressing the Need for Firearm Safety in Medical School Curricula

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The rate of firearm-related deaths in the United States is the highest among all industrialized countries, with more than 32,000 firearm-related deaths occurring each year, including homicides, suicides, and accidental deaths[1]; and

Whereas, The incidence of firearm-related mortality in the U.S. has increased in a 10-year period, from 10.3 deaths per 100,000 in 2007 to 12.0 deaths per 100,000 in 2017[2]; and

Whereas, The annual total cost of firearm-related death and injury in the United States was estimated at $229 billion in 2012, which includes direct costs of health care and emergency services and indirect costs, such as lost income for victims and caregivers[3,4]; and

Whereas, Prevention of avoidable firearm-related injury and death, and treatment of firearm-related psychiatric morbidity lies within the purview of medicine; and

Whereas, Physician-led firearm counseling was ruled protected under First Amendment rights by *Wollschlaeger v. Governor, State of Florida,* which invalidated Florida's Firearm Owners' Privacy Act that prevented physicians from asking patients about firearm ownership[5]; and

Whereas, Although most physicians agree they should have an active role in firearm-related injury prevention, they have been found to ask patients about firearms infrequently and to counsel poorly, if at all, when they do engage patients on this topic[6,7,8,9]; and

Whereas, Most physicians report low confidence and inadequate training in counseling firearm-related injury prevention counseling, which is due in part to a deficiency in medical training[7]; and

Whereas, In addition to the physical injuries due to firearms, firearm violence indirectly impacts the health of patients, families, and the community as a whole; and

Whereas, Physicians are intrinsically involved in helping patients cope with the emotional trauma experienced during and after an incident of gun violence[10]; and

Whereas, Children exposed to firearm violence or living in neighborhoods where firearm violence is common are more likely to abuse drugs and alcohol, suffer from psychiatric disorders, underperform in school, and be less physically active outdoors due to safety concerns[12]; and

Whereas, The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) has convened a working group to develop curricula to help educate future physicians about firearms safety[11]; and

Whereas, Numerous medical schools, including Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Icahn School of Medicine at Mount Sinai, McGovern Medical School, Miller School of Medicine, and Washington University School of Medicine in St. Louis have already incorporated firearm-related injury prevention education into their curriculum[12]; and

Whereas, Although American Medical Association policy H-145.976 advocates for "strategies for counseling patients on safe gun storage and use in undergraduate medical education", this does not encompass a broader inclusion of discussing the impacts of gun violence as a whole on our patients' health; therefore be it

RESOLVED, That our AMA support the addition of evidence-based firearm-related injury prevention education into medical school curricula; and be it further

RESOLVED, That our AMA support the inclusion of gun violence epidemiology and its social, economic, and emotional impact on families and the community into medical school curricula.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY:

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976
1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership,

access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

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.

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 64
(I-19)

Introduced by: Region 2; Region 4

Subject: Amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, to encourage ACEs and TIC training in undergraduate and graduate medical education

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Adverse childhood experiences (ACEs) includes physical or emotional abuse or neglect, loss of a parent, family discord and divorce, and exposure to alcohol or drug abuse and mental illness in the home, or violence in the home or neighborhood[1,2]; and

Whereas, A dose-dependent relationship between ACEs and lifelong negative health effects, including the leading causes of death, has been well-established over the last two decades[1-7]; and

Whereas, ACEs are distinct from other social and intrapersonal health risk factors, and ACEs screening is distinct from other pre-visit patient screening in that it provides a more expanded history of the patient (in contrast to screenings for substance use or abusive relationships)[8,9]; and

Whereas, Studies have shown that a majority of residents and physicians across multiple specialties are unfamiliar with the science behind ACEs, neglect to screen for ACEs, and underestimate the prevalence of ACEs in their patients[10-16]; and

Whereas, ACEs screening and trauma-informed care are not part of standard undergraduate or graduate medical training[17]; and

Whereas, Increased clinician recognition of trauma exposure and its clinical manifestations has been shown to reduce the impact of such adverse experiences on health, thereby improving care and patient outcomes[18-25]; and

Whereas, Adoption of ACEs screening and a low-intensity behavioral intervention (including parent education and social services referral) in a pediatric primary care setting resulted in an improved parent-child relationship, suggesting increased resilience which can mitigate the negative effects of ACEs [26-27]; and

Whereas, Educational interventions to teach medical students about the health effects of childhood trauma exposure and how to address it resulted in a majority of students reporting increased understanding of the health effects of ACEs, and/or increased comfort with (or likelihood of) asking about ACEs and responding to trauma disclosures[17-18,25]; and

Whereas, The American Academy of Pediatrics recommends that the growing body of evidence linking childhood toxic stress with lifelong impairments in learning, behavior, and physical and mental health, "be fully incorporated into the training of all current and future physicians"[28]; and

Whereas, The American Medical Association (AMA) supports evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs[29]; and

Whereas, AMA supports efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting[29]; therefore be it

RESOLVED, That our AMA encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians by amending H-515.952, "Adverse Childhood Experiences and Trauma-Informed Care," as follows:

Adverse Childhood Experiences and Trauma-Informed Care, H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

<u>3. Our AMA encourages undergraduate and graduate medical education programs to develop and implement training about ACEs and trauma-informed care into their curricula, including but not limited to the following:
a. ACEs and their dose-dependent relationship with lifelong adverse mental and physical health outcomes
b. How managing stressors and building resilience can mitigate the impact of ACEs on long-term health
c. How to address trauma and resilience with patients</u>

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:

a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

Family and Intimate Partner Violence H-515.965
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

Bullying Behaviors Among Children and Adolescents H-60.943
Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim;
(2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents;

(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression;
(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;
(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and
(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.

Preventing, Identifying and Treating Violence and Abuse 8.10
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements.
Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law.

Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Family Violence-Adolescents as Victims and Perpetrators H-515.981
The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or

its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 65
(I-19)

Introduced by: Region 4; Region 5; Student National Medical Association; Pooja Nair, University of Missouri Columbia School of Medicine

Subject: Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Remote Patient Monitoring (RPM) is a form of telemedicine that can be used by physicians to virtually monitor and manage patients' chronic conditions by using digital technology that securely stores and transmits patient physiologic data[1]; and

Whereas, There are three major forms of telemedicine: live video (synchronous), store-and-forward (asynchronous), and RPM[2]; and

Whereas, Telemedicine and telehealth policies to date have focused primarily on live-video sessions[3]; and

Whereas, Approximately 6 in 10 American adults live with at least one chronic condition and 42 percent have more than one[4]; and

Whereas, According to the Centers for Disease Control and Prevention, chronic conditions now account for the most deaths in the nation and take up more than 85 percent of annual healthcare expenditures[4]; and

Whereas, Access to healthcare is one of many major factors contributing to the higher rates of chronic illness and poorer overall health in rural communities residents compared to urban community residents[5,6]; and

Whereas, The use of RPM has been shown to improve health outcomes including lowered HbA1c levels, reduced mortality for patients with cardiac electronic implantable devices (CEIDs), reduced readmissions for Congestive Heart Failure (CHF) patients, and reduced hospitalizations, ER visits, and average number of bed days for military veterans with diabetes[7,8,9,10]; and

Whereas, RPM has been shown to reduce 30 day readmission rates for CHF patients from 28% to 0% for a cost savings of $216,000 per 30 day period at Brockton Hospital in Massachusetts[9]; and

Whereas, Employing RPM reduced healthcare utilization by 38% among heart failure patients with biventricular defibrillators without compromising patient safety in a multicenter randomized controlled trial[11]; and

Whereas, In the University of Mississippi's Diabetes Telehealth Network pilot program, the use of RPM was effective for reducing patients' HbA1c, cholesterol, LDL, HDL, and triglyceride levels, and improving creatinine clearance and GFR[12]; and

Whereas, Clarifying reimbursement is important for supporting the adoption of new technologies; and

Whereas, While all fifty states and Washington, D.C. provide reimbursement for some form of live-video sessions, only twenty one state Medicaid programs provide reimbursement for RPM[14]; therefore be it

RESOLVED, That our AMA amend policy D-480.969, Insurance Coverage Parity for Telemedicine Service to include remote patient monitoring as follows:

Insurance Coverage Parity for Telemedicine Service (D-480.969)

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services and remote patient monitoring services at a comparable rate to the fee schedule set by CMS, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies and to achieve adequate reimbursement of remote patient monitoring.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine and remote patient monitoring are ~~is~~ appropriately defined in each state's medical practice statutes and ~~its~~ their regulation falls under the jurisdiction of the state medical board

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics: 1.2.9 Use of Remote Sensing & Monitoring Devices
Sensing and monitoring devices can benefit patients by allowing physicians and other health care professionals to obtain timely information about the patient's vital signs or health status without requiring an in-person, face-to-face encounter. Implantable devices can also enable physicians to identify patients rapidly and expedite access to patients' medical records. Devices that transmit patient information wirelessly to remote receiving stations can offer convenience for both patients and physicians, enhance the efficiency and quality of care, and promote increased access to care, but also raise concerns about safety and the confidentiality of patient information.
Individually, physicians who employ remote sensing and monitoring devices in providing patient care should:
(a) Determine whether using one or more such devices is appropriate in light of individual patients' medical needs and circumstances, including patients' ability to use the chosen device appropriately.
(b) Explain how the device(s) will be used in the patient's care and what will be expected of the patient in using the technology, and disclose any limitations, risks, or medical uncertainties associated with the device(s) and data transmission.
(c) Obtain the patient's or surrogate's informed consent before implementing the device in treatment.
Collectively, physicians should:
(d) Support research into the safety, efficacy, and possible non-medical uses of remote sensing and monitoring devices, including devices intended to transmit biometric data and implantable radio frequency ID devices.
(e) Advocate for appropriate oversight of remote sensing and monitoring devices.

AMA Principles of Medical Ethics: I,III,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Payment for Electronic Communication H-385.919
Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.

1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.
Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
(i) establishing the patient's identity;
(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
(iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
Collectively, through their professional organizations and health care institutions, physicians should:
(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.

Coverage of and Payment for Telemedicine (H-480.946)
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Insurance Coverage Parity for Telemedicine Service (D-480.969)
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

Integration of Mobile Health Applications and Devices into Practice H-480.943
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated

devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

Evolving Impact of Telemedicine (H-480.974)
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

The Promotion of Quality Telemedicine (H-160.937)
1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:
A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.
B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.
C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.
D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.
E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.
F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.
H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.
2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.
3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.
4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education.
5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.

The Promotion of Quality Telemedicine (H-480.969)
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented

medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;
(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;
(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.
(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

Telemedicine Encounters by Third Party Vendors (D-480.968)
1. Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent.
2. The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information
3. Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.
4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Telemedicine Models and Access to Care in Post-Acute and Long-Term Care (D-480.966)
Our AMA will: (1) advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with relevant national medical specialty societies to effect a change in Medicare’s policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP); and (2) work with relevant national medical specialty societies and

other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients.

Access and Equity in Telemedicine Payments (D-480.970)
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists.

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.

VA Technology-Based Eye Care Services (H-510.982)
Our AMA encourages the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. veterans, including the Technology-Based Eye Care Services (TECS) program; and will work with Congress to ensure that U.S. veterans can access eye care through the TECS program.

480.001 MSS: Medical Technology Assessment
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 trails when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trails 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 AMA-MSS Digest of Policy Actions/ 117
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)

480.010 MSS: Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship

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 AMA-MSS Digest of Policy Actions/ 118
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 webbased tele-health technology and health care initiatives and the requirements of physicians

480.018 MSS: Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research

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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 66
(I-19)

Introduced by: Lekha Anatuni, Prudhvi Bandi, Natasha Sioda, Christopher Lee, Joel Eastes, Courtney Getchell, Katie Bring, Amy Yordduangjun, Braden Olsen, Tuan Ngo, Creighton University School of Medicine – Phoenix; Christopher Pardo, Hannah Meissner, Charlie Altfillisch, Meera Patel, Kari Strauss, Creighton University School of Medicine - Omaha

Subject: Hepatitis A Screening for At-Risk Populations

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Incidence of Hepatitis A outbreaks have risen by 294% between 2016 to 2018, compared to 2013-2015 in the United States -- most prominently in the homeless, drug abusing and men who have sex with men populations [1]; and

Whereas, 551 cases and 6 Hepatitis A-related deaths were reported in the past year in Arizona alone [2]; and

Whereas, In 2017, more than 650 individuals in California were infected with Hepatitis A (including 417 hospitalizations and 21 deaths), making this the largest outbreak in the United States in two decades [3]; and

Whereas, A study conducted during an outbreak in San Diego, CA reported that 64.7% of Hepatitis A-positive patients were homeless and 39.8% reported illicit or injection drug use [4]; and

Whereas, Michigan has responded to their largest Hepatitis A outbreak (928 cases and 28 deaths) with an emergency department protocol for screening the highest risk groups; and

Whereas, Since the start of their screening program in December 2017, Michigan's new cases of Hepatitis A has dropped significantly from 633 cases in 2017 to 219 in 2018 and 8 in 2019 [5]; and

Whereas, Michigan was able to reduce their number of Hepatitis A cases through vaccination clinics, community outreach programs, case-finding and post-exposure prophylaxis among other efforts, their strategy might not be as effective or feasible on a national scale[6]; and

Whereas, The CDC recommends Hepatitis A vaccinations for all persons experiencing homelessness over the age of 1 year due to a far greater benefit to vulnerable at-risk populations than cost of Hepatitis A hospitalizations, immunizations, and hepatitis treatment -- even when patients are lost to follow-up [7]; and

Whereas, Greater than 95% of immunocompetent adults who receive the Hepatitis A vaccine produce protective antibody within 1 month of receiving just 1 dose[7]; therefore be it

RESOLVED, That the AMA-MSS acknowledge the current national Hepatitis A outbreak and encourage further research into methods of containing and preventing future outbreaks that can be generalized to the entire US population.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

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.

Distribution and Administration of Vaccines H-440.877
1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.
2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.
3. Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.
4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.
5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.
6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.
7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.
8. Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

Pneumococcal, Influenza and Hepatitis-B Vaccines H-440.988
Our AMA advocates: (1) that patients at risk of pneumococcal or influenzal infections receive the appropriate vaccination;
(2) that individuals, including health care professionals at high risk of hepatitis-B infection, be given the informed option of receiving HBV vaccine. Until further experience has alleviated concerns about possible late hazards from this vaccine, a more widespread usage is not currently justified;
(3) study of possible solutions to the problems of payment for HBV and influenza vaccination for segments of the population at increased risk;
(4) research to improve the efficacy of pneumonia and influenza vaccines in selected populations and to develop artificial HBV antigens, with a view to reducing the cost to patients of this important new vaccine;

(5) physicians to follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention on the Prevention of Pneumococcal Disease; and
(6) third party payers to appropriately reimburse physicians for the administration of recommended vaccinations.

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Universal Immunization for Hepatitis B Virus H-440.958
Our AMA: (1) supports the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B; (2) encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition; (3) supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection; (4) encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation; and (5) encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 67
(I-19)

Introduced by: Region 5; Akhila Padi, University of South Carolina School of Medicine Greenville; Laura Barera, Uniformed Services University of Health Sciences

Subject: Oppose Tracking of People who Purchase Naloxone

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The number of opioid deaths has been steadily increasing over the past two decades; approximately 130 Americans die each day from opioid overdose[1]; and

Whereas, Naloxone hydrochloride is a competitive antagonist against the mu-opioid receptor that can be used to counteract the effects of opioids to reverse an overdose[2,3]; and

Whereas, Due to the rising prevalence of opioid use disorder (OUD), the FDA approved the use of naloxone products by bystanders who suspect opioid overdose[4]; and

Whereas, Naloxone has an established history of safe and effective use to combat opioid overdoses and has no abuse potential[5,6]; and

Whereas, Naloxone has few adverse effects and is very effective at reversing the actions of opioids; when given to healthy volunteers with no recent opioid exposure, naloxone has no clinical effect; when given to someone who is unresponsive for a reason other than opioid toxicity, naloxone is unlikely to cause harm[7,8]; and

Whereas, A prospective, randomized trial showed that intramuscularly- or intranasally-administered naloxone showed low rates of minor adverse events (e.g. headache, nausea, irritation) and major events (e.g. seizure) were not found[6]; and

Whereas, A systematic review on the management of opioid overdose with Naloxone reports low rates of death or adverse outcomes (0% to 1.25%) for patients who were administered naloxone and not brought to a healthcare facility[9]; and

Whereas, The World Health Organization (WHO) has recommended the widespread availability of naloxone to counteract opioid related deaths[10]; and

Whereas, Take-home naloxone programs are effective for reducing opioid-overdose mortality, and the efficacy of reversal by laypersons is 75-100%[4,8]; and

Whereas, Between 1996 and 2014, 644 local sites in 30 states and the District of Columbia distributed 152,000 naloxone kits and reported 26,000 successful drug overdose reversals[11]; and

Whereas, As of July 2017, all 50 states and the District of Columbia have passed laws that increase public access to naloxone and 43 states have issued standing orders allowing non-medical persons to obtain and administer naloxone[12,13]; and

Whereas, Reviews have found that expanding the supply of naloxone is not associated with compensatory drug use or greater risk-taking[14,15]; and

Whereas, Many people who purchase and use naloxone are friends, family, and community members who are not at risk of opioid overdose themselves, which means that the purchase of naloxone is not indicative of overdose risk[16–18]; and

Whereas, Federal law (42 Code of Federal Regulations, Part 2) protects patient confidentiality as it pertains to substance use treatment and does not require this information be placed in the electronic medical record[19]; and

Whereas, Naloxone purchased without a prescription will be recorded at the pharmacy of purchase[20]; and

Whereas, The state of Nebraska maintains a prescription drug monitoring program, which will track all dispensed prescriptions in the state including those for naloxone[24]; and

Whereas, In Massachusetts, a state with a standing order allowing healthcare workers to purchase naloxone, more than a half dozen employees at Boston Medical Center were denied life and disability insurance due to receipt of naloxone; this is a problem that has occurred in multiple states[25,26]; and

Whereas, The presence of any evidence of substance use treatment including naloxone purchases on a medical or insurance record may bias the provider and result in alteration of the care provided[21–23]; and

Whereas, Physicians who believe their patients have an OUD are less likely to provide them with appropriate pain management and are more likely to assume symptoms are due to their OUD[27]; and

Whereas, There is no data to support that tracking naloxone purchase history provides any health benefits, but it may reduce people's willingness to purchase naloxone[25,28]; and

Whereas, Various respected health organizations (e.g. AMA [H95.932], WHO, CDC) recognize the importance of increased access to naloxone and advocate for its widespread availability[29,30]; therefore be it

RESOLVED, That our AMA support naloxone purchasing guidelines that allow any person to purchase naloxone without being tracked or monitored; and be it further

RESOLVED, That our AMA oppose any policies that may require naloxone prescriptions or purchases to be tracked or monitored by non-healthcare providers.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and,

where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;

(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Prescription Drug Monitoring Program Confidentiality H-95.946
Our AMA will:
(1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial;
(2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and
(3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

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; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Naloxone Administration and Heroin Overdose 100.007MSS
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.

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
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 encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

OTC Availability of Naloxone: 100.013MSS
Ask the AMA to support the study of OTC availability of Naloxone.

Restrictions on Use of Physician Prescribing Data for Commercial Purposes 120.009MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 68
(I-19)

Introduced by: Region 1; Jack Gatti, Johns Hopkins School of Medicine

Subject: Restricting Use of Force by Law Enforcement Officers for Improved Public Health Outcomes

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Police violence against public citizens has been under increased public scrutiny throughout the United States (U.S.); and

Whereas, In 2017, 1,147 individuals were killed by police officers in the U.S., 149 of which were unarmed. Out of these unarmed victims, 49 (33%) were African American, 34 (23%) were Latino, and 2 (1%) were Native American, indicating that minority communities are disproportionately affected;[1] and

Whereas, The term “use of force” by police officers includes, but is not limited to, “the use of a firearm, taser, explosive device, chemical agent, baton, impact projectile, blunt instrument, hand, fist, foot, canine, or vehicle against an individual”;[2,3] and

Whereas, 92% of these mortalities were shootings and the remainder were accounted by other uses of force, including tasers, physical force, and police vehicles;[1] and

Whereas, Estimated lifetime medical costs are high for morbidities and mortalities resulting from police intervention, with an estimated $231 million from 2012;[4] and

Whereas, The “Use of Force Project” determined that officers in departments with more restrictive use of force policies killed fewer people per 1 million, killed fewer people per 100,000 arrests, were less likely to be killed in the line of duty, and were less likely to be assaulted compared to departments without restrictive use of force policies in areas with similar crime rates, including violent crime rates;[1] and

Whereas, This analysis found that inclusion of select use of force policies was associated with incremental percent fewer police killings per capita: requiring de-escalation (-15%), including a use of force continuum (-19%), banning chokeholds and strangleholds (-22%), requiring warning before shooting (-5%), restricting shots at moving vehicles (-8%), requiring exhaustion of all other means before shooting (-25%), requiring officers to intervene to stop another officer from using excessive force (-9%), and requiring comprehensive reporting including both use of force and threats of force (-25%);[1] and

Whereas, In 2014, police departments with three use of force policies had fewer than 0.02 mortalities of officers per 1,000 officers compared to police departments with one use of force policy, which had approximately 0.12 mortalities of officers per 1,000 officers;[1] and

Whereas, Cities that have voluntarily adopted the U.S. Department of Justice's recommendations for reform have observed a 32% reduction in shootings by police officers in the first year of implementation;[5] and

Whereas, As of 2019, the U.S. Department of Justice use of force policy does not explicitly have these requirements for law enforcement departments and, consequently, there remains significant variation among use of force policies across law enforcement departments;[6,7] and

Whereas, Entities supporting stricter use of force policies through the U.S. legislature include, but are not limited to, the U.S. Commission on Civil Rights and the American Civil Liberties Union;[8,9] and

Whereas, California recently passed AB-392, which specifies that law enforcement may only use deadly force when "necessary" as opposed to "reasonable," taking effect on January 1, 2020;[10] and

Whereas, Supreme Court judicial rulings in support of restricting use of force by the police and other governing officials include, but are not limited to, Tennessee v. Garner and Graham v. Connor;[11,12] and

Whereas, Use of force policies have been proposed in the U.S. Senate and the U.S. House of Representatives in 2019, which respectively include the Next Step Act, that supports federal law enforcement reform, and the Police Exercising Absolute Care with Everyone (PEACE) Act, that prohibits federal use of deadly force and incentivizes states to adopt similar legislature;[4,13] and

Whereas, The AMA recognizes that gun violence is a public health issue that threatens the safety of our communities (H-145.997), that police aggression, whether physical or verbal, is a social determinant of health can threaten public safety (H-515.955), and that the use of choke and sleeper holds in prison are considered deadly force (H-430.998); and

Whereas, The AMA has a public health role in law enforcement legislation at the national, state, and local levels, and current AMA policy reflects this: body-worn cameras for law enforcement officers should be implemented and regulated (D-160.919) and law enforcement departments and agencies should have guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (H-145.977).

Whereas, Current AMA policy only encourages study of the public health effects of physical or verbal violence between law enforcement officers and public citizens (H-515.955), but given the evidence of associated morbidity, mortality, healthcare costs, and use of force policy efficacy in terms of improved public health outcomes as stated above; therefore be it

RESOLVED, That our AMA work with interested national, state, and local medical societies in a public health effort to support legislation that restricts excessive use of force by law enforcement officers.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955.

Our AMA: 1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. 3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence

involving law enforcement. 4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. 5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Use of the Choke and Sleeper Hold in Prisons - H-430.998.
The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997.
1. 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: (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (B) 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; (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (D) 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; (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (F) 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 (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. 2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919.
Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to

better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs

440.054 MSS 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])y 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.

515.012 MSS 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)

515.011 MSS 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 69
(I-19)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville; Nicholos Joseph, Harvard Medical School

Subject: Supporting the Inclusion of Integrated Practice Units in Medical Care

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The United States healthcare system is the most expensive in the world and produces worse outcomes than comparable lower-cost health systems[1]; and

Whereas, A team at Harvard Business School, led by Dr. Michael Porter, developed a framework for restructuring our health care system around value for patients, and defined patient health outcomes per dollar spent to achieve those outcomes--this framework is known as the Integrated Practice Unit[2]; and

Whereas, Integrated Practice Units (IPUs) are organized around the patient to provide the full cycle of care for a medical condition--including patient education, engagement, and follow-up--to encompass inpatient, outpatient and rehabilitative care as well as supporting services[7]; and

Whereas, An Integrated Delivery System (IDS) is defined as “a network of healthcare facilities under a parent holding company”, while IPUs are a specific framework organized around the patient to provide encompassing healthcare, thus distinguishing IPUs from IDSs[13]; and

Whereas, IPUs incorporate the utilization of outcomes that matter to patients as the primary focus for designing care and joint accountability between physicians and other healthcare providers such as pharmacists, dietitians, physical therapists, etc. for the outcomes and costs of care[3]; and

Whereas, IPUs provide a centralized approach where patients can receive their care from a variety of specialties, and have a single administrative and scheduling structure--which from a provider’s perspective, significantly reduces duplication of effort, delays, and inefficiencies in care[9]; and

Whereas, The Integrated Practice Unit has successfully been implemented in many organizations, including the Cleveland Clinic[2]; and

Whereas, IPUs have been proven to be effective in providing patients with Parkinson’s Disease more efficient care and in helping to bridge gaps that normally divides providers, such as a lack of communication and differing locations where care is provided[3]; and

Whereas, IPUs have also proven to be effective for the treatment of conditions such as musculoskeletal disease, thyroid cancer, brain tumors, breast cancer, as well as in the primary care setting[4-5,8-12]; and

Whereas, In the Virginia Mason's Spine Clinic, which is an IPU, patients missed fewer days of work (4.3 versus 9 per episode) and needed fewer physical therapy visits (4.4 versus 8.8)[9]; and

Whereas, When the concept of the IPU was applied to a virtual ward program, there were 1,164 fewer bed days from the index admission to 90 days post-discharge with an associated cost savings of S$1,250,655, 109 fewer ED attendances with associated cost savings of S$23,544, and the number of 30-day ED attendances for patients was 40% lower, all with no adverse effects, proving that IPUs reduce readmissions in patients who are at high risk of unplanned hospital readmissions[6]; and

Whereas, Our AMA supports credible models of providing coordinated, comprehensive, accountable, cost-effective, patient-centered care (AMA Policy H-390.843); therefore be it

RESOLVED, That our AMA support the use of Integrated Practice Units in medical care for patients with chronic medical conditions.

Fiscal Note: TBD

Date Received:09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

A Guide to Selecting a Physician-Led Integrated System D-160.926
Our AMA, in collaboration with the Integrated Physician Practice Section and appropriate partners within the House of Medicine, will accomplish the following by the 2017 Annual Meeting:
1. Develop a guide for physicians considering joining or aligning with a physician-led integrated system that addresses, but is not limited to the following:
A. various models of integrated systems;
B. metrics that help determine the extent to which an integrated system fulfills the definition of, and performs as, an integrated system;
C. how to determine an organization's quality commitment/record;
D. how to know if a particular system is the right fit;
E. what does a physician stand to gain/lose when joining such a system; and
2. The guide should also provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value based care.

The Critical Role of Physicians in Health Plans and Integrated Delivery Systems H-285.931
Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS):
(1) Practicing physicians participating in a health plan/IDS must:
(a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing body or management;
(b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;
(c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine;
(d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and
(e) have access to a due process system.
(2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.
(3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.
(4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.
(5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.

(6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.
(7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.
(8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.
(9) Physician representatives/leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.
(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice.
Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.

Physician Led, Single and Multi-Specialty, Organized Group Practice Models H-390.843
1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care.
2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost.

Recognizing the Diversity of Practice Models in the Transition from the SGR to a Higher Performing Medicare Program H-390.844
1. Our AMA continues to advocate for a transition from the sustainable growth rate payment formula to new payment models that:
    A. Emphasize the importance of physician leadership and accountability to deliver high quality and value to our patients;
    B. Reflect and preserve the diversity of physician-led practice models (including, for example, integrated systems of care, patient-centered medical homes, regional health collaboratives, and other practice models, including private practice); and
    C. Provide opportunities for physicians to determine payment models that work best for their patients, their practices, their specialties, and their regions.
2. Our AMA, while working to help implement new payment models, continues to advocate that:
    A. fee-for-service, as well as private practice medicine, be included as continued options that can provide efficient, ethical, high quality, high value, patient-centered care;
    B. the viability of a private practice option be preserved for the benefit of patients and our members; and
    C. physicians should be free to determine the basic method of payment for their services, and have the right to establish their compensation arrangements including

private contracting at a level which they believe fairly reflects the value of their professional judgment and services.

3. Our AMA continues to educate members on Medicare payment and delivery issues as they develop.

Strategies to Address rising Health Care Costs H-155.960

Our AMA:

(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;

(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;

(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and

(d) promote "value-based decision-making" at all levels;

(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;

(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;

(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;

(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and

(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.

(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Principles of the Patient-Centered Medical Home H-160.919

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.

The Patient Centered Medical Home H-160.918
Our AMA:
1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.

3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
    a. Focus the team on patient and family-centered care.
    b. Make clear the team's mission, vision and values.
    c. Direct and/or engage in collaboration with team members on patient care.
    d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
    e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
    f. Encourage adherence to best practice protocols that team members are expected to follow.
    g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
    h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
    i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
    j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
    k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.
(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.
(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.
(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in

the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.
(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Incorporating Community Health Workers into the U.S. Health Care System 200.018MSS
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.

The Patient Centered Medical Home Concept 385.002MSS
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 within the setting of a patient-centered medical home.

Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students 295.142MSS
(1) AMA-MSS will ask the AMA to recognize that inter- professional 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 70
(I-19)

Introduced by: Isabella Caldwell, Palavi Vaidya, University of Toledo College of Medicine

Subject: Opposition of Corporal Punishment as a Form of Discipline

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Over 75% of parents in the United States admit to using corporal punishment with their children under the age of 8, sometimes as young as only 12 months of age[4,5,13]; and

Whereas, Corporal punishment is defined as physical punishment causing pain or discomfort for a response to a child's behavior[14]; and

Whereas, 54 countries in the world have banned corporal punishment of children which has lead to significant decreases in student-to-student violence in these countries[15]; and

Whereas, Current institutions like he American Academy of Pediatrics (AAP) and the United Nations (UN) have issued policies that do not endorse corporal punishment[2]; and

Whereas, Even with a partial ban on corporal punishment in the United States in schools, in 19 states it is still legal to use corporal punishment in schools[11]; and

Whereas the UN has created a worldwide movement to protect children from punishment stated under the UN Convention on the Rights of the Child[16]; and

Whereas, There is substantial evidence that the use of corporal punishment is ineffective and ultimately increases a child's risk of negative behavioral or developmental outcomes[1,13]; therefore be it

RESOLVED, That the AMA-MSS opposes the use of corporal punishment in any setting; and be it further

RESOLVED, That the AMA-MSS promotes parental education on the negative effects of corporal punishment in addition to educating them on more effective discipline strategies.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Corporal Punishment in Schools, H-515.995
The AMA (1) supports the abolition of corporal punishment in schools; (2) encourages universities that train teachers to emphasize alternative forms of discipline during their training; 3) encourages physicians to work towards the abolition of corporal punishment in their

communities; and (4) encourages state medical societies to support legislation prohibiting corporal punishment in their state.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 71
(I-19)

Introduced by: Region 1; Region 3; Region 5

Subject: Support for Siblings of Chronically Ill Children

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Nearly 43% of US children are currently living with at least 1 of 20 recognized chronic childhood illnesses including cerebral palsy, cystic fibrosis, and developmental disabilities[1]; and

Whereas, Nearly 1 in 408 children will be diagnosed with cancer before the age of 15, and 1 in 285 children are diagnosed with cancer before the age of 20, with rates of diagnoses increasing since 1975[2]; and

Whereas, Chronic pediatric illnesses affect the healthy siblings' relationship with their parents and their ill sibling[3]; and

Whereas, Siblings of pediatric cancer patients face psychological and emotional challenges associated with chronic illness, including experiencing feelings of loneliness, jealousy, guilt, and anxiety[4]; and

Whereas, Studies have shown that bereaved patients report difficulty sleeping, reduced self-esteem and maturity as long as nine years after a sibling's death[4]; and

Whereas, These siblings experience difficulties in school including decreased attendance and performance but may benefit from relationships with their teachers and peers[5]; and

Whereas, Interventions for well-being have a positive effect on the psychological functioning of siblings of children and young people with a chronic illness[6]; and

Whereas, Summer camp programs designed specifically for pediatric oncology patients and their siblings to interact and share their experiences have improved campers' reports of perceived social support and self-esteem[7], as well as improved understanding of their emotions and the emotions of others[8]; and

Whereas, A study with 2114 children across 19 summer camps indicated that summer camp programs can be beneficial for pediatric oncology patients and their siblings by improving social, emotional, physical, and self-esteem functioning, regardless of demographic factors and whether camp sessions included patients only, siblings only, or both, and[7]

Whereas, A study of 56 siblings of pediatric patients with disabilities enrolled in a cognitive-behavioral support group program were shown to have fewer emotional and behavioral problems immediately after the program as well as at a 3-month follow up compared to their peers who were not enrolled in the program[9]; and

Whereas, AMA policy supports providing resources to the caregivers of patients with chronic illnesses but does not specifically address the needs of siblings [H-210.980]; therefore be it

RESOLVED, That our AMA supports programs and resources that improve the mental health, physical health, and social support for siblings of chronically ill pediatric patients.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

H-210.980 Physicians and Family Caregivers: Shared Responsibility

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for **Adverse Childhood** Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 72
(I-19)

Introduced by: Carly Polcyn, University of Toledo; Clara Liu, Kansas City University of Medicine and Biosciences; Jennifer Talbott, Mayo Clinic Alix Schools of Medicine – Arizona; Imaima Casubhoy, Kansas City School of Medicine

Subject: Restrictions on the Unlicensed Sale of Guns at Gun Conventions

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Brady Handgun Violence Prevention Act requires federal background checks only for guns purchased from Federal Firearms License holders at U.S. gun shows, and does not apply to private unlicensed sellers of firearms (1); and

Whereas, Such sellers utilize the “gun show loophole,” wherein they classify as private sellers to avoid federal licensing as long as selling firearms is not their primary source of income under the Firearm Owners Protection Act (2); and

Whereas, The Federal Bureau of Alcohol, Tobacco, Firearms, and Explosives estimates that a significant portion of gun sales at gun shows, up to 25%, happen via unlicensed, private sellers (2); and

Whereas, 32 states do not have mandatory registration and licensing systems on private sales of firearms at gun shows (3); and

Whereas, Research has shown it is more difficult for criminals and juveniles to purchase guns in cities with mandatory state registration and licensing systems (4); and

Whereas, Individuals with criminal records can bypass gun regulations by obtaining firearms from unlicensed sellers at gun shows (3); and

Whereas, There is a positive correlation between firearms purchased at gun shows and increased incidence of firearms injuries (5); and

Whereas, It has been shown that states with mandatory registration laws exhibit lower rates of suicide by firearm (6); and

Whereas, It has been shown that over 90% of firearm related homicides are committed by unlicensed gun owners (6); therefore be it

RESOLVED, Our AMA encourages stronger gun safety measures by supporting stricter legislation on the unregulated sale of firearms and amending policy H-147.996 as follows:

Firearm Availability, H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers regardless of whether the seller is a Federal Firearm License holder; (b) encourages legislation that enforces a waiting period and background checks for all firearm purchasers regardless of whether the seller is a Federal Firearm License holder; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms owners, purchasers, and sellers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence(7). In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Fiscal Note:

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Firearms Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm

purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Firearms as a Public Health Problem in the United States H-145.997
1. 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:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) 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;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) 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;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) 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

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Firearms: Safety and Education 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:

(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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 73
(I-19)

Introduced by: Region 7; Region 2

Subject: Opposing Efforts that would Prevent Transgender or Questioning Youth from being Prescribed Puberty-Suppressing Medications by Physicians

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Children and adolescents who are transgender or gender non-conforming (TGNC) represent a small yet significant portion of youth that consistently show worse health outcomes compared to their cis-gender peers[1]; and

Whereas, Gender non-conforming adolescents between the ages of 10-17 are more likely to suffer from mental health conditions, such as anxiety, depression, and suicidal ideation compared to their cis-gender peers[2]; and

Whereas, Increasing numbers of TGNC youth are being prescribed GnRH agonists, or "puberty blockers", which suppress the development of secondary sex characteristics[3,4]; and

Whereas, The Endocrine Society recommends that "Gender-dysphoric/gender-incongruent persons should receive a safe and effective hormone regimen that will suppress the body's sex hormone secretion, determined at birth and manifested at puberty, and maintain levels of sex steroids within the normal range for the person's affirmed gender", and that "clinicians [should] begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty"[5]; and

Whereas, Transgender adolescents after treatment with puberty blockers experience fewer depressive symptoms and less emotional and behavioral problems[3]; and

Whereas, Puberty blockers reduce the number of surgeries and procedures needed later for transgender patients to make the physical changes that better align with their gender identity[6]; and

Whereas, Transgender youth who are treated with puberty blockers and later gender affirmation surgery have psychological well-being similar to same-age, cis-gender adults in the general population[7]; and

Whereas, Puberty blockers have known side effects, including reduced bone density and reduced fertility[8,9]; and

Whereas, Puberty blockers are a low-risk intervention with few immediate side effects, and discontinuation likely causes normal pubertal changes to resume[5,10,11,12]; and

Whereas, Patients work closely with a multidisciplinary team consisting of physicians, mental health workers, and other professionals to ensure that their individual benefits of treatment outweigh the risks[5,10]; and

Whereas, Recent state-level efforts have been made to prevent providers from prescribing puberty suppressing medications[13,14]; and

Whereas, The Trump administration has taken actions that limit transgender access to healthcare[15,16]; and

Whereas, Other challenges that prevent TGNC youth from accessing puberty-suppressing medications include poor insurance coverage for this class of drugs, a lack of specialized multidisciplinary gender clinics, and a lack of providers trained at caring for the unique health needs of this population[13,17,18]; and

Whereas, While current AMA policy advocates for the medically necessary care of gender dysphoria, it fails to protect TGNC youth access to this specific and potentially life-saving class of medications[19]; therefore it be

RESOLVED, That our AMA oppose efforts that would prevent transgender or questioning youth from being prescribed puberty-suppressing medications by physicians.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

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.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients H-460.907
Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients.

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 74
(I-19)

Introduced by: Hannah Meissner, Albert Dickan, Dan Markunas, Rafael Peralta Creighton University; Kajal Madan, Rishitha Panditi, Sahil Patel, Sriharsha Voleti, Northeast Ohio Medical University; Justin Magrath, Tulane University School of Medicine

Subject: Support for the Creation of a "Verified Badge" for Vaccine-Related Information Websites

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, 75-90% of internet users search for health information and 70% report that their findings affect their health decisions[1]; and

Whereas, Over half of internet users believe "almost all" or "most" information found on health websites is credible based on factors other than content such as website design, features, and personalization[2]; and

Whereas, A controlled study found that parents who opted not to vaccinate their children are more likely to have received their information online compared to parents who opt to vaccinate[3]; and

Whereas, The internet is the main source of anti-vaccination misinformation, allowing 'anti-vaccine' groups to have immense influence[1;4]; and

Whereas, There have been 38,521 reported cases of vaccine-preventable diseases, not including hepatitis A or B, in the year 2016 alone[5]; and

Whereas, The number of unvaccinated children has quadrupled since 2001[6]; and

Whereas, The World Health Organization (WHO) has listed vaccine hesitancy as one of its top 10 health threats facing the world in 2019[7]; and

Whereas, A "verified" badge, generally denoted by a blue checkmark near a user's name, is a tool used by social media companies including Twitter, Facebook, and Instagram to verify the authenticity of an account[8-10]; and

Whereas, The authenticity created by a "verified" badge prevents social media consumers from being misled by accounts impersonating public figures/entities[11]; and

Whereas, Currently there is no way to easily tell what vaccine-related health information is from a reliable, licensed health professional; and

Whereas, A health information "verified" badge could similarly protect consumers from inaccurate and misleading health information on websites, increasing the trustworthiness and authenticity of verified sites; therefore be it

RESOLVED, That our AMA support the creation of a "verified" badge to be displayed on websites that offer credible vaccine-related information when using a search engine; and be it further

RESOLVED, That the credibility of the website's information be determined by a group such as the AMA, American Public Health Association, the Centers for Disease Control and Prevention, the Food and Drug Administration, or other similar entity.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of

evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (f) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

National Immunization Program H-440.992
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease:
(1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.
(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.
(3) There should be no financial barrier to immunization of children.
(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.
(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.
(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.
(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.
(8) An efficient immunization record-keeping system should be instituted.

Nonmedical Exemptions from Immunizations H-440.970
Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are

common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.

Immunization Registries H-440.899
Our AMA encourages: (1) physicians to participate in the development of immunization registries in their communities and use them in their practices for patients of all ages; (2) electronic health record (EHR) vendors to add features to automate the exchange of vaccination information in the patient EHR to state immunization registries to improve and help ensure completeness and accuracy of vaccination records. EHR vendors and registry administrators need to work with physicians and other health professionals to facilitate the exchange of needed vaccination information by establishing seamless, bidirectional communication capabilities for physicians, other vaccine providers, and immunization registries; and (3) all states to move rapidly to provide comprehensive lifespan immunization registries that are interfaced with other state registries

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 75
(I-19)

Introduced by: Student National Medical Association; Sachin Kothari, Mevish Siddiq, Medical College of Georgia; Vivek Kothari, Mercer University School of Medicine; Gautam Pathak, Sanika Satoskar; Northeast Ohio Medical University

Subject: Utilization of Telesurgery in Rural America

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Telemedicine generally encompasses live videoconferencing, transmission of medical images/information, and remote patient monitoring[1]; and

Whereas, Telesurgery is a specialized form of telemedicine, featuring robotic surgical devices that enable surgeons to operate on patients remotely[2]; and

Whereas, Rural areas face barriers such as a higher incidence of chronic disease and a shortage of surgeons, and can benefit from telesurgery[3]; and

Whereas, For example, percutaneous coronary intervention (PCI) is the preferred intervention for myocardial infarction (MI) with better post-MI complications[4]; and

Whereas, PCI has the potential to save lives with a door-to-balloon time of 90 minutes, and those who cannot make it to the catheterization lab in 90 minutes are indicated to be treated with fibrinolytics[5]; and

Whereas, PCI is more beneficial than thrombolytics or fibrinolytics such as tPA (tissue plasminogen activator) which carry risk of bleeding and do not treat plaque stenosis as effectively[6]; and

Whereas, 50 million Americans live outside of a one-hour travel time to the nearest PCI center and are forced to be treated with tPA if unable to reach a PCI facility[7]; and

Whereas, Rural residents have a median driving time of 67 minutes to the nearest PCI center, compared with a mere 30 minutes for urban residents, leading to worse health outcomes[7]; and

Whereas, Residents of rural areas had 8 times higher chances of mistimed access to PCI compared with residents in urban areas[7]; and

Whereas, Telesurgery with remote PCI poses a unique solution to this dire problem; and

Whereas, In India, the first long-distance telerobotic PCI was successfully performed on 5 rural patients from a city 32 kilometers away with no complications[8]; and

Whereas, With existing 21st century technology, telesurgery such as PCI has been successfully performed in a developing country and could also be utilized in rural America; and

Whereas, Current AMA policy encourages the collaboration of AMA Councils and working groups on matters of new and developing technology, particularly … telemedicine (G-615.035); and

Whereas, Current AMA policy (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, and (2) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public (H-465.994, Improving Rural Health Care); therefore be it

RESOLVED, That our AMA-MSS encourage utilization of telesurgery to help rural Americans with access to the best existing surgical interventions.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Improving Rural Health Care H-465.994
The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

Technology and the Practice of Medicine G-615.035
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 76
(I-19)

Introduced by: Region 1; Saima Wase, Northeast Ohio Medical University

Subject: Supporting External Accountability for ICE and CBP

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Between 2016 and the end of fiscal year 2017, ICE removed 61,000 immigrants and arrested 110,00 people, representing a 37% increase in immigrant removals and a 42% increase in arrests from an equivalent period in the previous year[1]; and

Whereas, Congress reached a bipartisan deal limiting the number of U.S. Immigration and Customs Enforcement (ICE) detainees to 40,520 people per day and provided only enough funds to cover this target while repeatedly rejecting requests by ICE for increased detention funding[2,3]; and

Whereas, ICE has exceeded this number, detaining an average of 55,530 individuals per day as of August 2019, up from an average of 34,000 detainees per day between 2008 and 2016[4]; and

Whereas, In order to house this many detainees without Congressional funding, ICE has begun detaining migrants at three for-profit prisons that had previously been shut down due to concerns about the treatment and well-being of inmates housed there: the Adams County Correctional Center, a Mississippi prison operated by CoreCivic; the Catahoula Correctional Center, a Louisiana jail run by LaSalle Corrections; and the South Louisiana ICE Processing Center, run by GEO Group in Basile, Louisiana[2,3]; and

Whereas, There has yet to be any punitive consequences for ICE's violation of Congressional orders[2]; and

Whereas, ICE is overseen by the Department of Homeland Security (DHS) Office of Inspector General, DHS Office of Civil Rights and Civil Liberties, and ICE Office of Detention Oversight, yet has no external standards regarding the level of care it must provide to the detainees[5]; and

Whereas, In January 2019 the Department of Homeland Security (DHS) Office of the Inspector General inspected ICE's contracted detention facilities and found 14,000 health and safety deficiencies mainly related to physical and mental healthcare procedures for detainees[6]; and

Whereas, The DHS Office of the Inspector General found that "ICE has no assurance that it executed detention center contracts in the best interest of the Federal Government, taxpayers, or detainees"[7]; and

Whereas, ICE is currently being sued by the Southern Poverty Law Center and various other advocacy groups including the Civil Rights Education and Enforcement Center and the Disability Rights Advocates for violation of Section 504 of the Rehabilitation Act, 29 U.S.C. 794, and for multiple civil infractions for denying access to medical care to immigrants with and without disabilities[5]; and

Whereas, In December 2017, following Executive Order 13767, ICE reversed a prior policy banning the detainment of pregnant women[8]; and

Whereas, Since this change in policy, testimonies from detained pregnant women have alleged inadequate access to prenatal care[9,10]; and

Whereas, A medical record review conducted by ICE found the rate of detainees suffering a miscarriage has doubled since 2017 with many of these occuring in the second trimester[10]; and

Whereas, ICE recently raided seven food processing plants in Mississippi, violating privacy and immigrant rights by tracking ankle monitors placed on people released from detention centers to target and arrest almost 700 undocumented immigrants[10,11]; and

Whereas, Some of the arrested undocumented immigrants were the sole caretakers for their children, leaving those children without a parent or guardian[12]; and

Whereas, ICE was not required to put any safety protocols into place for those children including notifying child protective services and guaranteeing that each affected child had an appropriate guardian or caretaker at home[12]; and

Whereas, U.S. Customs and Border Patrol (CBP) apprehended 466,623 individuals between ports of entry on the Southwest Border in 2018 and 657,404 individuals have already been apprehended as of August 2019[13]; and

Whereas, Apprehended individuals are typically taken into CBP short-term holding facilities and these facilities are not governed by any external statutes or regulations[14]; and

Whereas, There are internal policies and memorandums detailing that detainees should not be held in short-term facilities for more than 72 hours and that “detainees will be provided snacks and meals, given access to potable drinking water, will have access to bathrooms and toilet items, will be given necessary medical attention, and further, agents will make reasonable efforts to provide a shower for detainees held for more than 72 hours and detention cells will be regularly cleaned and sanitized”[14]; and

Whereas, Reports have come out detailing that immigrants, including children, have often been held by CBP in these short-term facilities for days to months in cramped cells, often without being given enough food and water, and sometimes with no access to soap, toothpaste, clean diapers for infants, or places to wash their hands and shower[15-18]; and

Whereas, Some reports have emerged of children sleeping on concrete floors in extreme cold and adults having to stand for days due to lack of space[15]; and

Whereas, There have been outbreaks of flu, lice, chicken pox, and scabies within immigrant detention facilities[19,20]; and

Whereas, There have been reports of young children being left without caretakers in CBP facilities, border patrol agents laughing at and taunting children while they cry, and punitively leaving lights on to prevent immigrants from sleeping[18,21,22]; and

Whereas, Thousands of children have filed reports of sexual assault while in U.S. custody including allegations of sexual assault by border patrol agents and staff members[23,24]; and

Whereas, Research indicates alterations of brain architecture with potential to impede development in cognition, education, and emotional maturity in children with a history of traumatic events[25]; and

Whereas, The North Carolina Medical Journal wrote testimony that migrant children can experience an exacerbation of mental illnesses from prior trauma as a direct result of separations from family and living conditions in detention centers[26]; and

Whereas, The Human Rights Office at the U.N. issued a statement saying the detention of migrant children, "may constitute cruel, inhuman or degrading treatment that is prohibited by international law,"[27]; and

Whereas, On August 21, 2019, the Trump administration introduced a new rule enabling immigration officials to detain migrant families indefinitely while those families' asylum cases are heard, replacing a prior 20-day limit on child and family detentions[28]; and

Whereas, In June 2019, the inspector general's office issued a 69-page audit on disciplinary practices across the Department of Homeland Security, including CBP which found "the department does not have sufficient policies and procedures to address employee misconduct" and advocacy experts have reported that allegations of misconduct at CBP are frequently dealt with at the local level by supervisors rather than professional investigators at any of the internal bodies tasked with overseeing CBP if they are dealt with at all[29]; and

Whereas, Increased oversight from 2008 to 2016 and a decrease in the length of time immigrants were being held in CBP and ICE detention centers lead to a drastic decrease in the rate of immigrant deaths from 11.9 per 100,000 in 2004 to 2.8 per 100,000 in 2016[30]; and

Whereas, Current ICE and CBP policies are converting back to a lack of accountability, regulatory oversight, and increased immigrant detention times and immigrant in-custody death rates have already started to trend back upward from 2.8 per 100,000 in 2016 to 3.7 per 100,000 in 2017[30]; and

Whereas, Twenty-four immigrants have died in ICE custody in the last two years up from an average of 8 immigrant deaths per year from 2008 to 2016, seven children have died in U.S. custody after being detained by ICE and/or CBP following over a decade of zero in custody immigrant child deaths, and the U.S. government has lost track of 1,475 immigrant children many of who came into the custody of the U.S. government after being arbitrarily separated from their caregivers by CBP[30-35]; and

Whereas, The only external action that has occurred in response to reports of human rights abuses and violations of internal policy by both ICE and CBP has been for the House Committee on the Judiciary and the House Committee on Oversight and Reform to hold hearings questioning high ranking officials in both ICE and CBP[36,37]; therefore be it

RESOLVED, That our AMA-MSS support restructuring, including but not limited to increased external oversight and regulation, of U.S. Immigration and Customs Enforcement as well as U.S. Customs and Border Protection to better promote the health and well-being of immigrants and their families who are affected by immigration raids and who are held in detention by these two agencies.

Fiscal Note: TBD

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RELEVANT AMA AND AMA MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. Res. 017, A-17

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. Res. 254, A-18

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958
Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations 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. Res. 013, A-19

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. Res. 018, A-17

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

Improving Medical Care in Immigration Detention Centers 350.016MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations 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. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. MSS Res 22, A-17, Immediate Transmittal; AMA Res 017, A17 Adopted as Amended [D-350.983]

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS
(1) That our AMA 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 (2) That our AMA amend AMA policy H-20.901 by addition and deletion to read as follows:

> 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. (3) That this resolution be forwarded immediately to the House of Delegates at A-18. MSS Res 01, A-18

Opposing the Office of Refugee Resettlement's use of Medical Psychiatric Records for Evidence in Immigration Court 250.030MSS
That our AMA advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children (2) That our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. MSS Res 15, I-18

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask that our AMA-MSS Digest of Policy Actions/ 94 350.016MSS 350.017MSS 350.018MSS AMA 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]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 77
(I-19)

Introduced by: Region 3; Jay Patel, Koshala Selvakumar, Northeast Ohio Medical School

Subject: Encouraging Brain and Other Tissue Donation for Research and Educational Purposes

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Postmortem tissue contains invaluable information that can be used for medical research and educational purposes to improve our understanding of human physiology and pathophysiology and thus enhance patient care[1]; and

Whereas, Recent research using postmortem brain tissue has been critical to our understanding of the pathogenesis of neurological and psychiatric illnesses such as Parkinson's disease, dementia, PTSD, autism, and major depression and builds upon advances from neuroimaging, genetic, biomarker, and animal studies[2,3,4,5,6,7,8]; and

Whereas, States have taken efforts to raise awareness of and increase donation for organ transplant, such as by asking individuals if they would like to join transplant donor registries when they apply for or renew their driver's licenses[9,10]; and

Whereas, In Texas alone, nearly 7 million people have joined the Texas Donor Registry since a question regarding organ donation for transplantation was added to driver's license applications[11]; and

Whereas, 98% of organ donation registration occurs at the Bureau of Motor Vehicles and promotional materials and clerk educational training has been shown to increase organ donation registration by up to 7.8%[10,12]; and

Whereas, Although some states including Texas offers an option for organ donation and/or tissue donation for research purposes on donor cards, brain tissue donation requires a separate consenting process that often occurs after death through the next of kin[13,14];and

Whereas, Willed body program recruitment is not standardized across institutions and can create a large financial and logistic burden on institutions[1]; and

Whereas, Widespread efforts to inform individuals of the importance of tissue donation for research and health professions education and allow interested individuals the opportunity to easily provide informed consent to donate their bodies for research or education purposes could increase donation rates, decrease costs, and eliminate the need for families to make decisions for their loved ones post mortem[15]; and

Whereas, These efforts could include strategies used to increase organ donation for transplantation, such as asking individuals if they would like to donate other tissue for research purposes when applying for or renewing a driver's license[10]; and

Whereas, A study of public perceptions surrounding whole body donation found that 58.8% of participants reported insufficient understanding of the body and tissue donation process for research and educational purposes, 77.4% reported that they did not know how to register to become a whole body donor and 23.9% reported that they did not know they could be registered as both a transplant organ donor and whole body donor or tissue donor[16]; and

Whereas, Several studies have found that after receiving information about the tissue donation process, the majority of participants would be likely or somewhat likely to donate their brain tissue (>60%) for research[17,18,19]; and

Whereas, While current AMA policies H-370.984, H-370.995, H-370.996, and H-370.998 address increasing public education and donation rates for transplantation, they do not address ethical or scientific benefits when postmortem tissue donation serves a scientific or educational purpose; therefore be it

RESOLVED, That our AMA encourage efforts to provide educational materials to the public and health professionals regarding the importance of postmortem tissue donation including but not limited to neural, ophthalmic, and other tissue needed for research and educational purposes and the methods through which one can become a tissue donor; and be it further

RESOLVED, That our AMA encourage the inclusion of additional options for brain and other tissue donation for research purposes on donor cards; and be it further

RESOLVED, That our AMA urge the citizenry to consider consenting to signing donor cards for tissue donation for research purposes; and be it further

RESOLVED, That our AMA encourage efforts to facilitate recovery of postmortem tissue including but not limited to neural, ophthalmic, and other tissue for research and educational purposes.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Importance of Clinical Research H-460.930
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the

research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports the development of community and practice-based clinical research networks.

Physician Involvement in Research E-7.1.1
Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.
However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.
Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) and individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.
Physicians who are involved in research with human participants have an ethical obligation to ensure that participants' interests are protected and to safeguard participants' welfare, safety, and comfort.
To fulfill these obligations, individually, physicians who are involved in research should:
(a) Participate only in those studies for which they have relevant expertise.
(b) Ensure that voluntary consent has been obtained from each participant or from the participant's legally authorized representative if the participant lacks the capacity to consent, in keeping with ethics guidance. This requires that:
(i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;
(ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;
(iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.
(c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.
(d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.
(e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
(f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating the results of the research.

Organ Donation D-370.985
Our AMA will study potential models for increasing the United States organ donor pool.

Organ Donation and Honoring Organ Donor Wishes H-370.998
Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs**.**

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.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

Tissue and Organ Donation H-370.983
Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. Res. 533, A-92 Reaffirmed: CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 6, A00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.995
Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors;(2) the success rate for organ transplantation;(3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and(6) the ethical considerations of organ donor recruitment. Res. 32, A-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.996
Our AMA (1) continues to urge Americans to sign donor cards; (2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular; (3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card; and (4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation. CSA Rep. D, A-81 Reaffirmed: CLRPD Rep. F, I-91 Appended: Res. 509, I-98 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Importance of Autopsies H-85.954
1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.
2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical

procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.
3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.
4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.
5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.
6. Our AMA calls upon all third-party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third-party payers for autopsies.
7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.
8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.

Endorsement of the Uniform Anatomical Gift Act (2006) H-370.968
Our AMA endorses the Uniform Anatomical Gift Act of 2006 and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA.

Organ Donation Education H-370.984:
"Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes."

Improving Body Donation Regulation H-460.890
Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Organ Donation After Cardiac Death Code of Medical E-6.1.2
Increasing the supply of organs available for transplant serves the interests of patients and the public and is in keeping with physicians' ethical obligation to contribute to the health of the public and to support access to medical care. Physicians should support innovative approaches to increasing the supply of organs for transplantation while balancing this obligation with their duty to protect the interests of their individual patients.
Organ donation after cardiac death is one approach being undertaken to make greater numbers of transplantable organs available. In what is known as "controlled" donation after cardiac death, a patient who has decided to forgo life-sustaining treatment (or the patient's authorized

surrogate when the patient lacks decision-making capacity) may be offered the opportunity to discontinue life support under conditions that would permit the patient to become an organ donor by allowing organs to be removed promptly after death is pronounced. Organ retrieval under this protocol thus differs from usual procedures for cadaveric donation when the patient has died as a result of catastrophic illness or injury.

Donation after cardiac death raises a number of special ethical concerns, including how and when death is declared, potential conflicts of interest for physicians in managing the withdrawal of life support for a patient whose organs are to be retrieved for transplantation, and the use of a surrogate decision maker.

In light of these concerns, physicians who participate in retrieving organs under a protocol of donation after cardiac death should observe the following safeguards:

(a) Promote the development of and adhere to clinical criteria for identifying prospective donors whose organs are reasonably likely to be suitable for transplantation.

(b) Promote the development of and adhere to clear and specific institutional policies governing donation after cardiac death.

(c) Avoid actual or perceived conflicts of interest by:

(i) ensuring that the health care professionals who provide care at the end of life are distinct from those who will participate in retrieving organs for transplant;

(ii) ensuring that no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death

(d) Ensure that the decision to withdraw life-sustaining treatment is made prior to and independent of any offer of opportunity to donate organs (unless organ donation is spontaneously broached by the patient or surrogate).

(e) Obtain informed consent for organ donation from the patient (or surrogate), including consent specifically to the use of interventions intended not to benefit the patient but to preserve organs in order to improve the opportunity for successful transplantation.

(f) Ensure that relevant standards for good clinical practice and palliative care are followed when implementing the decision to withdraw a life-sustaining intervention.

Studying Financial Incentives for Cadaveric Organ Donation E-6.1.3

Physicians' ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence.

Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

(a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.

(b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.

(c) Has been developed in consultation with the population among whom it is to be carried out.

(d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.

(e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

Presumed Consent & Mandated Choice for Organs from Deceased Donors E-6.1.4
Organ transplantation offers hope for patients suffering end-stage organ failure. However, the supply of organs for transplantation is inadequate to meet the clinical need. Proposals to increase donation have included studying possible financial incentives for donation and changing the approach to consent for cadaveric donation through "presumed consent" and "mandated choice."
Both presumed consent and mandated choice models contrast with the prevailing traditional model of voluntary consent to donation, in which prospective donors indicate their preferences, but the models raise distinct ethical concerns. Under presumed consent, deceased individuals are presumed to be organ donors unless they have indicated their refusal to donate. Donations under presumed consent would be ethically appropriate only if it could be determined that individuals were aware of the presumption that they were willing to donate organs and if effective and easily accessible mechanisms for documenting and honoring refusals to donate had been established. Physicians could proceed with organ procurement based on presumed consent only after verifying that there was no documented prior refusal and that the family was not aware of any objection to donation by the deceased.
Under mandated choice, individuals are required to express their preferences regarding donation at the time they execute a state-regulated task. Donations under mandated choice would be ethically appropriate only if an individual's choice was made on the basis of a meaningful exchange of information about organ donation in keeping with the principles of informed consent. Physicians could proceed with organ procurement based on mandated choice only after verifying that the individual's consent to donate was documented.
These models merit further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh the ethical concerns.
Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:
(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
(b) Has been developed in consultation with the population among whom it is to be carried out.
(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool 370.015MSS
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.
Increasing Organ Donation Discussions through Medical Education 370.010MSS
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.

Organ Donation Education Programs in Driver Training Programs 370.012MSS
AMA-MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs.

Presumed Consent Organ Donation 370.013MSS
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.

Improving body donation regulation 370.020MSS
That our AMA recognize the need for ethical, transparent, and consistent body donation regulation

Targeted Education to Increase Organ Donation 70.016MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 78
(I-19)

Introduced by: Laura Barrera, Kristan Baird, Steven Mowen, Uniformed Services University of the Health Sciences

Subject: Supporting the use of Telemedicine to Screen and Diagnose Autism Spectrum Disorder

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder which, according to the U.S. Centers for Disease Control and Prevention (CDC), is identified in 1 in 59 children[1]; and

Whereas, Diagnosing ASD takes two steps: developmental screening and a comprehensive diagnostic evaluation; and[2]

Whereas, The American Academy of Pediatrics recommends screening for autism occurs at 18 and 24 months, along with regular developmental surveillance[3]; and

Whereas, Pediatricians will first screen children for autism before referring them to specialized medical centers where the wait time to evaluation and diagnosis is often six months to one year[1]; and

Whereas, Many studies have shown that early diagnosis is critical, however, a major contributing factor to delayed diagnosis relates to the challenge of accessing diagnostic clinics and developmental pediatricians[1]; and

Whereas, Pediatricians will first screen children for autism before referring them to specialized medical centers where the wait time to evaluation and diagnosis is often six months to one year[1]; and

Whereas, Children aged birth to three years who are identified with developmental delay will, at their state's discretion, have access to early intervention services provided by their respective states as outlined by the Individuals with Disabilities Education Act (IDEA) 2004 part C[4]; and

Whereas, Children and adults ages 3-21 identified with developmental delay and related disorders are entitled to special education services as outlined by the IDEA 2004 Part B[5]; and
Whereas, preliminary results from a recent study done by Vanderbilt University showed remote diagnosis of autism was feasible and accurate for young children, further, remote clinicians accurately identified 62 percent of children who ultimately received a diagnosis of ASD, resulting in a sensitivity of 78.2 percent overall[6]; and

Whereas, A study evaluating interactive videoconferencing for assessing symptoms in autism indicated no significant difference in reliability or diagnostic accuracy for those physicians who observed in person versus via telemedicine, and demonstrated increased parent satisfaction vs. traditional in-patient diagnosis[7]; and

Whereas, AMA strongly supports the development of high quality telemedicine services as reflected in H-4.80.974, H-480.968, D-480.970; and

Whereas, AMA urges physicians to assist parents in obtaining access to appropriate individualized early intervention services as evident in H-90.969; therefore be it

RESOLVED, That our AMA support telecommunication as a means by which children in American states and its territories can undergo screening and diagnosis of can be screened for and diagnosed with Autism Spectrum Disorder and Development Delay by physicians.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Evolving Impact of Telemedicine H-480.974
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Access and Equity in Telemedicine Payments D-480.970
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined ‘shortage’ areas, if that area can show a shortage of those physician specialists.

Coverage of the Payments for 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.

Early Intervention for Individuals with Developmental Delay H-90.969
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 79
(I-19)

Introduced by: Abdoulie Njai, Calli Morris, University of Missouri School of Medicine; Peter Palmer, Nikhil Datla, Jay Patel, Nick Dalagiannis, Grant Weltlin, Northeast Ohio Medical University; Venkata Tekumalla, University of Alabama-Birmingham School of Medicine

Subject: Early Sports Specialization in Youth Athletes

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The level of competitiveness and desire to reach elite levels in sports has shifted athletics towards intense sport-specialized training among youth and high school athletes, defined as intense, year-round training in a single sport with the exclusion of other sports[1]; and

Whereas, However, sports specialization has been shown to have significant impacts on youth and high school athletes, both physically, due to the vulnerability of joints, connective tissue, and growth cartilage that can be damaged by repeated microtraumas during growth, and mentally[2, 3, 4, 5]; and

Whereas, A 2016 study by the National Federation of State High School Associations (NFHS) found that moderately specialized athletes had a 50% increased risk and highly specialized athletes had an 85% increased risk of injury compared to athletes with a low level of specialization[2]; and

Whereas, A study involving 2721 high school athletes showed that increased exposure was the most important risk factor for injury and that there is a linear relationship between exposure and risk of injury, with significantly elevated risk once training exceeded 16 hours per week[3]; and

Whereas, The International Olympic Committee published a consensus statement on youth athletic development recommending that children be encouraged to participate in a variety of different activities and develop a wide range of skills and avoid specialization until at least puberty[9]; and

Whereas, Early specialization can also lead to psychological stress and burnout in youth athletes, with athletes having decreased motivation, a lack of enjoyment, high perceived stress and anxiety, ineffective or limited stress coping strategies, and mood disturbances[5]; and

Whereas, Burnout has been defined to occur as a result of chronic stress that causes a young athlete to cease participation in a previously enjoyable activity. Studies suggest that athletes who had early specialized training withdrew from their sport due to either an injury or a burnout from the sport[13].

Whereas, Sports diversification, defined as participation in a variety of sports and activities, during childhood has been found to increase long-term participation, increased adult performance, and increased personal development, without hindering elite-level participation in sports where peak performance occurs after maturation[10, 11]; and

Whereas, Although many youth athletes have the desire to train to become star athletes in their primary sport, studies have shown that Division I NCAA athletes are more likely to have played multiple sports in high school and that their first organized sport was different from their current one[6]; and

Whereas, Moreover, professional baseball players in the MLB are more likely to experience upper and lower extremity injuries, as well as play in less games during their careers, when they only play baseball in high school compared to those that played multiple sports.[12]

Whereas, National organizations have began creating guidelines regarding sports specialization, with the NBA and USA Basketball releasing guidelines in 2016 for youth basketball that recommended delaying specialization for young players until they're 14 or older, limiting high-density scheduling based on age-appropriate guidelines through high school, and ensuring rest from organized basketball at least one day a week and extended time away each year[7]; and

Whereas, The American Academy of Pediatrics has stated that participating in multiple sports, at least until puberty, decreases the chances of injuries, stress, and burnout in young athletes. The AAP also states that early diversification and later specialization provides for a greater chance of lifetime sports involvement, lifetime physical fitness, and possibly elite participation[6]; and

Whereas, Although policy H-470.959 and H-470.999 each support physicians in establishing guidelines for how to promote safe and healthy practices to help protect youth athletes, we don't believe that they adequately consider the growing issues with sports specialization; therefore be it

RESOLVED, That our AMA recommend early sports diversification and later specialization in youth athletes to decrease the chances of injuries, physiological stress, and burnout; and be it further

RESOLVED, That our AMA recommend close monitoring of the physical and psychological health of sports specialized athletes by physicians, trainers, coaches, and parents/guardians of the athlete to ensure long-term health and well-being.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY:

Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959
1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and 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 be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.
3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents;(b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school

personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.
4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

Youth Physical Fitness H-470.998
The AMA and its state and local components should reemphasize their support of local school and college youth fitness programs.

Youth Fitness H-470.999
Our AMA: (1) approves in principle the aims and objectives of the President's Council on Fitness, Sports, and Nutrition and urges its member physicians to cooperate in the promotion of properly developed and soundly conceived plans and programs for youth fitness; and (2) requests the constituent associations and their member local medical societies to work cooperatively with reputable professional and other ethical groups interested in the improvement of youth fitness.

470.003MSS 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, I03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 80
(I-19)

Introduced by:	Region 2; Region 3; Region 7; Neya Sterling, Northeast Ohio Medical University
Subject:	Peripartum Mental Health Coverage Under Children's Insurance
Referred to:	MSS Reference Committee (Pauline Huynh, Chair)

Whereas, Peripartum depression is defined as a major or minor depressive disorder with a depressive episode occurring during pregnancy or within the first year after childbirth[1]; and

Whereas, One in seven women suffer from peripartum depression during the first year of motherhood[1]; and

Whereas, Estimated rates of depression among pregnant and postpartum women range from 10-25% depending on socioeconomic status and additional risk factors[1]; and

Whereas, Postpartum screening can maximize the health of both mothers and newborns and provides an important opportunity to identify factors that can affect maternal and newborn health, such as peripartum depression[2]; and

Whereas, Untreated peripartum depression can interfere with a mother's ability to care for her child and can lead to problems with the child's physical, cognitive, and behavioral development[3,4]; and

Whereas, The World Health Organization recommends all mothers and newborns receive at minimum three postpartum visits from time of delivery to six weeks postpartum, where each visit includes psychosocial support to prevent peripartum depression[6]; and

Whereas, Regular monitoring and support during the first three months of the postpartum period can optimize maternal mental health and reduce the risk of suicide, especially among mothers with a history of psychiatric disorders[5]; and

Whereas, Several barriers prevent women from accessing peripartum depression screening and care, including limited access to care, financial and geographic barriers, scarcity of mental healthcare professionals, societal and familial stigma, and lack of peripartum depression education and awareness[1]; and

Whereas, The American Academy of Pediatrics recommends screening for maternal peripartum depression during pediatric visits[4]; and

Whereas, In 2016, the US Centers for Medicare and Medicaid Services published best practices supporting that state Medicaid programs cover peripartum depression screening as part of a pediatric well-child visit[7]; and

Whereas, As of 2018, screening for perinatal depression during the pediatric well-child visit is a covered benefit under state Medicaid programs in twenty-five states[8]; and

Whereas, In 2018, Texas added peripartum depression screening and counseling as covered benefits under Children's Medicaid and the Children's Health Insurance Program (CHIP), which allows low-income mothers who are ineligible for Medicaid or are otherwise uninsured to still receive mental healthcare under their child's insurance[9]; therefore be it

RESOLVED, That our AMA, in order to expand access to peripartum mental healthcare for more uninsured women, amend AMA Policy H-420.953, "Improving Mental Health Services for Pregnant and Postpartum Mothers," by insertion as follows:

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum, including, but not limited to, coverage of mental health services under a child's health insurance plan; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
; and be it further

RESOLVED, That our AMA, in order to expand access to general postpartum maternal care for more uninsured women, amend AMA Policy H-420.953, "Improving Mental Health Services for Pregnant and Postpartum Mothers," by insertion as follows:

Extending Medicaid Coverage for One Year Postpartum D-290.974
1) Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.
2) Our AMA will work with relevant stakeholders to support coverage of peripartum maternal healthcare under a child's health insurance plan, including but not limited to Children's Medicaid and Children's Health Insurance Program (CHIP) plans, for women who are ineligible for Medicaid or are otherwise uninsured for at least 12 months postpartum.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 81
(I-19)

Introduced by: Haritha Pavuluri, Tristan Mackey, University of South Carolina School of Medicine Greenville

Subject: Supporting Social Comparison Feedback Initiatives to Improve Physician Stewardship

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, 56 million people in the United States struggled to pay health care costs in 2013[1]; and

Whereas, Diagnostic tests and screenings are a significant component of unnecessary health costs[2]; and

Whereas, More judicious use of such diagnostic tests and screenings can improve health care quality and reflect awareness of costs and high-value care[2]; and

Whereas, A housestaff-led initiative at Vanderbilt University Medical Center involving regular data feedback with peer comparison resulted in a 4.1% increase in patients with lab-free days (0 labs ordered in 24 hours) for medical housestaff and a 9.7% increase for hospitalist intervention services, when compared to the group who did not receive peer feedback[3]; and

Whereas, The University of Virginia Medical Center conducted a similar, chief-resident-led initiative in which internal medicine residents received a weekly email containing individualized and team daily lab-ordering practices in comparison with those of their peers, which resulted in an immediate and sustainable reduction in repetitive laboratory utilization[4]; and

Whereas, Social comparison feedback is an “increasingly popular strategy that uses performance report cards to modify physician behavior”[5]; and

Whereas, A peer comparison feedback initiative at the Hospital of the University of Pennsylvania resulted in a significant decrease in orders among participants who deviated more from the peer rate[5]; and

Whereas, A review of methods to reduce test utilization in hospital settings found peer comparison initiatives reduced test order volume and successfully reduced unnecessary laboratory testing, and that residents who saw the resident and service utilization averages ordered 0.26 fewer labs per doctor-patient-day than those who did not[6]; and

Whereas, Our AMA supports value-based decision making in health care settings (H-450.938), an emphasis on cost and quality consciousness (H-155.966), strategies to address rising health care costs, and reducing health system costs that do not contribute value to patient care (H-155.960); therefore be it

RESOLVED, That our AMA support the inclusion of peer comparison feedback initiatives by amending H-155.998, Voluntary Health Care Cost Containment by addition as follows:

Voluntary Health Care Cost Containment, H-155.998

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead, and incorporate peer-comparison feedback initiatives, with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

Fiscal Note: TBD

Date Received: 09/20/2019

References:

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RELEVANT AMA AND AMA-MSS POLICY

Physician Stewardship of Health Care Resources 11.1.2
Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.
To fulfill their obligation to be prudent stewards of health care resources, physicians should:(a) Base recommendations and decisions on patients' medical needs.
(b) Use scientifically grounded evidence to inform professional decisions when available.
(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.
(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.
Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:
(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.
(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.
AMA Principles of Medical Ethics: I,V,VII,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Voluntary Health Care Cost Containment H-155.998
(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily

contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.
Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.
Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.
Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.
Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Value-Based Decision-Making in the Health Care System H-450.938
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.

Controlling Cost of Medical Care H-155.966
The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Strategies to Address Rising Health Care Costs H-155.960
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Listing of Hospital Charges 155.001MSS
AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, housestaff, 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.

Cost Containment 155.002MSS
AMA-MSS will ask the AMA to encourage medical schools and hospitals to orient medical students beginning in their clinical training and the housestaff to the costs of laboratory tests and procedures.

Comparative Effectiveness Research 460.011MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 82
(I-19)

Introduced by: Region 2; Creighton AMA Section; Ayushi Sharma, Charles Altfillisch, Meera Patel, Creighton University School of Medicine; Sahana Harikrishnan, Northeast Ohio Medical University.

Subject: Metformin Education for Diabetes Mellitus Type 2 Patients with Chronic Kidney Disease

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Metformin is a safe and effective blood sugar-lowering diabetes mellitus type 2 (DMT2) drug, with low cost generics and few side effects[1,2]; and

Whereas, The American Diabetes Association (ADA) guidelines suggest metformin as first line of defense for DMT2, even in the context of chronic kidney disease (CKD)[3]; and

Whereas, Patients that receive medical education in the context of diabetes have more well-controlled diabetes and improved Hgb A1c levels[4]; and

Whereas, The Food and Drug Administration (FDA) eliminated the contraindication between heart failure and DMT2 patients taking metformin, but have not removed the contraindication between elevated creatinine levels and patients with moderate renal dysfunction[5]; and

Whereas, The FDA has formally recommended against starting metformin therapy in patients with CKD with estimated glomerular filtration rate (eGFR) between 30 and 45 mL/min/1.73m^2, which is classified as stage G3b moderate CKD[6,7]; and

Whereas, The ADA states that it is safe and efficacious to use metformin down to a GFR of 30 mL/min/1.73m^2 in the context of DMT2[8]; and

Whereas, CKD can severely disrupt glucose homeostasis, thus exacerbating DMT2[9]; and

Whereas, Approximately 1 million Americans are not receiving adequate, tested DMT2 therapy with metformin due to a now-unfounded risk of increased lactic acidosis in the context of CKD in individuals with an eGFR of >30 mL/min/1.73m^2 [10]; and

Whereas, Patients can safely continue to take metformin in the setting of moderate to severe CKD with appropriate caution and be made aware that the risk of developing lactic acidosis while on metformin is minimal[6,11] and

Whereas, Despite the fact that healthcare professionals are aware that education and metformin therapy reduces the risk of DMT2 among patients with prediabetes, real-world incorporation remains low[12]; therefore be it

RESOLVED, That our AMA-MSS supports efforts to improve patient education, counseling, and shared decision-making regarding the relative risks and benefits of taking metformin when a patient has been diagnosed with both diabetes mellitus type 2 and chronic kidney disease.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

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

Health Care Delivery H-160.931
Our AMA: (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment; (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting; (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information; (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills; (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills; (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies; (7) encourages the allocation of federal and private funds for research on health literacy; (8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit; (9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and (10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.
CSA Rep. 1, A-98Appended: Res. 415, I-99Modified and Reaffirmed: CSAPH Rep. 1, A-09Appended: Res. 718, A-13

National Diabetes Program H-440.861
Our AMA formally endorses the work of the National Diabetes Education Program (NDEP), a joint venture of the National Institutes of Health, the Centers for Disease Control and Prevention, and over 200 organizations, and will seek inclusion in the NDEP Steering Committee to help guide the development of diabetes educational materials in line with existing AMA policy.
BOT Action in response to referred for decision Res. 604, I-07Reaffirmed: CSAPH Rep. 01, A-17

Patient Navigation Programs H-373.994
1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
    a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.

b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.

3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.

CMS Rep. 7, I-11 Appended: CMS Rep. 7, I-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 83
(I-19)

Introduced by: Region 3; Region 4; Region 5; Student National Medical Association; Rowena Hann, Touro University College of Osteopathic Medicine

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: MSS Reference Committee (Pauline Huynh, Chair)

Whereas, School-related arrests and juvenile justice referrals have been associated with school disengagements, lower graduation rates, increased dropout rates, and increased involvement in the school-to-prison pipeline[1, 2]; and

Whereas, School-related arrests and juvenile justice referrals disproportionately target black students, Latino students, male students, and students with physical or mental disabilities[3, 4, 5]; and

Whereas, Research on the effectiveness of school resource officer programs is limited, and fails to make a strong case for harsh discipline programs that include referral to law enforcement[6]; and

Whereas, School-based mental health efforts have been successful in identifying those in need of mental health services, bolstering academic functioning, and improving patterns of behavior[7]; and

Whereas, Educators, nurses, and counselors can play a key role in fostering protective environments for children and identifying students who may need additional support, in contrast to school resource officers[8, 9]; and

Whereas, School-based mental health professionals report ever-increasing workloads and responsibilities that include disciplinary roles[10, 11]; and

Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental health, or social issues because they do not feel that their disclosure will be kept private, possibly affecting their academic or conduct standing[12]; and

Whereas, The American School Counselor Association urges that “school counselors maintain non-threatening relationships with students to best promote student achievement and development” and states that school counselors are neither “disciplinarians” or “enforcement agent[s] for the school”[13]; and

Whereas, The National Association of School Nurses states that school nurses should facilitate an “environment that values connecting students, families, and the community in positive engagement” characterized by “safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf”[14]; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the

academic, social, emotional, and behavioral competence of students at all levels of education[15]; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"[15]; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior[16]; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions[17, 18]; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of “zero tolerance” policies and have advocated for school-wide PBIS as an alternative[19, 20]; and

Whereas, AMA policy H-60.919 includes support for “school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments,” but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs, but does not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our AMA support Positive Behavior Interventions and Supports (PBIS) programs or similar evidence-based frameworks in K-12 schools that (1) focus on school-wide prevention and intervention strategies for student misbehavior and (2) prioritize the health and well-being of students who are referred for disciplinary action; and be it further

RESOLVED, That our AMA work with school districts and educators to develop best practices for determining the role of school-based mental health professionals in the discipline process.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Juvenile Justice System Reform, H-60.919
Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development andlocal public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

School-Based and School-Linked Health Centers, H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Adolescent Health, H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17

Providing Medical Services Through School-Based Health Programs, H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

Improving Pediatric Mental Health Screening, H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Res. 414, A-11; Appended: BOT Rep. 12, A-14

Access to Mental Health Services, H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making

proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 84
(I-19)

Introduced by: Region 5; Avneet Soin, David Davila, Tufts University School of Medicine

Subject: Increased Recognition and Treatment of Eating Disorders in Minority Populations

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The DSM-V defines a binge-eating episode as “eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances”[1]; and

Whereas, The DSM-V defines the essential feature of binge-eating disorder (BED) as “recurrent episodes [of] binge eating that must occur, on average, at least once per week for 3 months”[1]; and

Whereas, Binge eating disorder is the most prevalent eating disorder in the United States with a lifetime prevalence of 2.8%[2]; and

Whereas, Recent evidence has shown significant differences in the prevalence of binge eating symptoms in non-Hispanic White populations and non-Hispanic Black populations[3]; and

Whereas; Rates of obesity, body satisfaction, and depression vary among ethnic groups causing heterogeneity in the prevalence of eating disorders within these groups[4,5]; and

Whereas; Some studies suggest that the increased risk of disordered eating in ethnic minority adolescents may result from higher levels of stress due to minority status[6]; and

Whereas; It has been further suggested that among these adolescents, physical appearance is viewed as a source of social capital, increasing their risk for engaging in unhealthy eating behaviors as a means of changing their appearance[6]; and

Whereas, Research has shown that men and ethnic/racial minorities are statistically significantly less likely to seek help for binge eating disorders than women or non-Hispanic whites[7]; and

Whereas, Studies have documented lower rates of treatment for eating disorders among some specific diverse populations due to differences in clinical presentation, differences in help-seeking patterns, and clinician error or bias[8-10]; and

Whereas, The phrase 'acculturative stress' refers to "the adjustment and internal conflict that often occur as an individual attempts to resolve cultural differences...during the acculturation process"[11]; and

Whereas, Recent evidence from a study of Latina and Asian American women has shown that acculturative stress may contribute to disordered eating[11]; and

Whereas, Interventional counseling is a broad term that does not have a standardized definition and therefore

Whereas, A recent overview of Cochrane systematic reviews has shown that of all studied psychosocial interventions, the cognitive behavioral approach was most effective for binge-eating disorder, bulimia, nervosa, and night eating syndrome[15]; and

Whereas, For example, a qualitative study has shown that culturally adapted CBT-guided self-help has been well received and is a feasible treatment for Mexican American women with binge-eating disorder[14]; and

Whereas, Research suggests culturally sensitive cognitive behavioral therapy (CBT) is both feasible and efficacious[12,13], and

Whereas; Binge-eating is the most prominent presentation of eating disorders, particularly in minority populations, but is not specified in current AMA policy despite less prevalent presentations such as weight restriction being specified; therefore be it

RESOLVED, That our AMA amend policy H-150.965 by insertion as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:

> **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 is 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, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally informed interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS 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 is 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.

Eating Disorders and Promotion of Healthy Body Image H-150.928
Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

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.

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

School-Based Prevention of Eating Disturbances in Adolescents 60.008MSS
AMA-MSS will ask the AMA to encourage all school counselors, coaches, trainers, teachers and nurses to be trained to recognize unhealthy dieting and weight restrictive behaviors in adolescents and offer education and appropriate referral for interventional counseling. (MSS Sub Res 18, I-97) (AMA Amended Res 503, A-98 Adopted [H-150.965]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

Promotion of Healthy Body Image in Pre-Adolescent Children 60.015MSS
AMA-MSS will ask the AMA to support school-based primary prevention programs for pre-adolescent children in order to prevent the onset of eating disorders and other behaviors associated with a negative body image. (MSS Res 11, I-05) (AMA Res 420, A-06 Referred)

(CSAPH Rep 8, A-07 Adopted [D-150.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations 350.013MSS
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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 85
(I-19)

Introduced by: Matthew Riley, Alexandria Wellman, Leighton Kraft, Southern Illinois University School of Medicine

Subject: Medicaid and Medicare alone without supplemental coverage of outpatient chemotherapy ambulatory pump for patients with colorectal and esophageal cancer.

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, Chemotherapy for colorectal and esophageal cancer is a part of the standard of care for affected patients with these illnesses [1, 2]; and

Whereas, Administration of chemotherapy is either done as an outpatient through chemotherapy portable pump or inpatient through infusion under physician care[3]; and

Whereas, Outpatient chemotherapy is a reliable and accepted drug delivery method[3]; and

Whereas, Outcomes for both inpatient and outpatient are similar[4]; and

Whereas, According to the 2016 American Hospital Association Annual survey, hospitals across the United States costs on average $2,129 for state/local government hospitals, $2,574 for nonprofit hospitals and $1,996 for-profit hospitals[5]; and

Whereas, Outpatient chemotherapy administration was found to be about $300 less than inpatient treatment and $2,200 per cycle[1, 3]; and

Whereas, A majority of patients prefer the ambulatory pump to inpatient treatment[4]; and

Whereas, The chemotherapy pump gives patients increased autonomy and personal freedom; therefore be it

RESOLVED, That our AMA support that Medicaid and Medicare provide coverage for chemotherapy pumps for outpatients undergoing treatment for colorectal and esophageal cancers.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

H-55.986 Home Chemotherapy and Antibiotic Infusions
Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' supervision, and encourages CMS and/or other insurers to provide adequate reimbursement for such treatment; and (2) supports educating legislators and administrators about the benefits of such treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide access to such treatments by appropriate reimbursement policies.

H-220.946 Unreasonable Burden of The Joint Commission Standards and Surveys
The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care.

H-330.899 Medicare Pharmaceutical Benefit
Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit:
(1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures.
(2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes and those with catastrophic costs.
(3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions.
(4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible.

(5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior.
(6) Any pharmaceutical benefit should be designed to prevent adverse selection.
(7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions.
(8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians.
(9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies.
(10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.

535.001 MSS Commendation to the AMA Board of Trustees
AMA-MSS will ask the AMA to continue pursuing goals to health care cost containment. (MSS Sub Res 6, A-84) (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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 86
(I-19)

Introduced by: Bryana Baginski, Akhila Padi, Dory Askins, Haritha Pavuluri, University of South Carolina School of Medicine – Greenville; Natasha Venugopal, Augusta University; Antara Afrin, Michigan State University College of Human Medicine

Subject: Amending H-95.922, Substance Use and Substance Use Disorders, to Include Standardization of Substance Use Disorder Screening

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, An estimated 20.7 million people over the age of 12 years old suffered from substance use disorder (SUD) in 2017, costing more than $740 billion dollars to the American society[1,2]; and

Whereas, Clinically significant impairment in health and responsibilities of daily living secondary to alcohol and/or illicit drug use qualifies under substance use disorder[2]; and

Whereas, As of August 2019, the U.S. Preventive Services Task Force (USPSTF), US Surgeon General's "report on Alcohol, Drugs, and Health", and the Substance Abuse and Mental Health Service Administration recommends screening for illicit drug use in adults[3,4]; and

Whereas, Only 0.5% to 5.0% of patients with substance use disorder were identified as needing treatment when using current screening methods[5]; and

Whereas, Effective treatment and care can be offered or referred, screening for accurate diagnosis of unhealthy drug use or substance use disorders has moderate benefits, which may be limited by the resources for treatment[4]; and

Whereas, Although the USPSTF recommends tools for alcohol use screening, there are no recommended tools for illicit drug use screening[6]; and

Whereas, The available tools for substance use disorder screening are variable and none are reinforced as in the case of alcohol use by the USPSTF[7]; and

Whereas, Despite recommendations for routine SUD screening, approaching the conversation of substance use can be difficult and lack of a systematic screening may serve as a barrier[3]; and

Whereas, Providers cannot simply rely on remembering to raise the concern of substance use; specific tools for screening and basic intervention are needed[3]; and

Whereas, Reasons for not implementing standardized screening tools for substance use disorder include logistical concerns, such as whether resources are available for treatment with a positive screening[1]; and

Whereas, However, with the increasing resources and treatment options for substance use disorder, it is more imperative than ever to implement standardized screening since SUDs increase risk of physical and mental health problems to patients[6,8]; and

Whereas, Recent studies demonstrate that screening itself has some therapeutic effect, especially if combined with brief intervention or appropriate resources[9]; and

Whereas, The various tools available currently for screening range from focusing on one substance only to being lengthy for a provider to perform regularly[8]; and

Whereas, Current screening methods have a high rate of false negatives and thus may lead to a cost burden on the healthcare system[7]; and

Whereas, Our AMA recognizes the significant negative impact of substance abuse and acknowledges that SUD diagnosis and treatment requires the use of screening tools, which need to be provided to physicians in order to appropriate access to care for patients suffering from such disorders (H-95.975, H-95.922, H-95.922); therefore be it

RESOLVED, That our AMA amend H-95.922 as follows:

Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) <u>support the standardization of tools used for screening with improved sensitivity and specificity to encourage accurate diagnosis and appropriate resources; (d) mandate screening for substance use disorder in order to provide early diagnosis and intervention</u>; (e) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (f) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA: a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth; b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics; c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends; d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions

can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to: a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Substance Use Disorders as a Public Health Hazard H-95.975
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach; (2) declares substance use disorders are a public health priority; (3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction; (4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and (5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Standardization of Collection and Custody Procedures of Body Fluid Specimens H-95.963
It is the policy of the AMA to seek to have standardized procedures, containers and forms developed that will satisfy the requirements of all requesting entities which will reduce the hassle which currently exists in processing specimens for drug screens and for insurance applications.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 87
(I-19)

Introduced by: Raveen Sugantharaj, Kaitlyn Brown, Marian University College of Osteopathic Medicine

Subject: Standardization of Human Trafficking Data and Medical Training

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Palermo Protocol and the Trafficking Victims Protection Act (TVPA) of 2000, as amended, defines “severe forms of trafficking in persons” both globally and nationally [1]; and

Whereas, AMA policy H-65.966 Physicians response to victims of human trafficking (HT) utilizes the US Department of State definition for human trafficking [2]; and

Whereas, An estimated 199,000 incidents of human trafficking occur within the United States each year and over 300,000 of America’s youth population is considered to be at risk for sexual exploitation [3]; and

Whereas, According to one study, 87.8% of HT victims encounter a healthcare provider throughout the course of their captivity and 68.3% of those victims were evaluated in an emergency department, yet went unidentified by their provider [4]; and

Whereas, Multiple organizations have developed curriculum and offer training in clinical settings regarding human trafficking; however, the content of these methods varies significantly, with minimal objective evaluations of their effectiveness, influence on practitioner behavioral changes, and subsequent victim-centered outcomes [5,6]; and

Whereas, Current medical training on how to interact with victims, how to screen for sexual trafficking during an encounter, and what to do in an acute response to suspected cases are insufficient and require further research, standardized protocol development, and training [7-9]; and

Whereas, AMA policies: H-65.966 Physicians response to victims of human trafficking, 515.008MSS The Identification and Protection of Human Trafficking Victims, and H-406.998 Role of Physicians and Physicians Organizations in Efforts to Collect Physician-Specific Health Care Data, all include language supporting the continued improvement of educational and training material for physicians as well as encouraging the development of physician specific data collection initiatives [2, 10, 11]; and

Whereas, The American Academy of Family Physicians (AAFP) supports “calls for increased funding for research on the health and public health consequences of human trafficking and encourages training programs to integrate education on human trafficking into existing curricula at the pre-doctoral, residency & CME levels” [12]; and

Whereas, Research suggests HT training and evaluation would benefit from an agency or institution at the national level to provide consistency and standardization of HT training content

as well as to guide a process to develop metrics for evaluation and the building of an evidence base; [5,6] and

Whereas, The United States Government 2019 Trafficking in Persons (TIP) Report recognizes voids and unaddressed aspects in national research and data collection of human trafficking and, therefore, recommends evidence-driven and unbiased evaluation of human trafficking in order to create an improved anti-trafficking response [1]; and

Whereas, Victim and trafficker data has proven difficult to collect, organize, manage, access, protect, and utilize; therefore, the TIP recommends the formation of organizations with the funding to develop well-designed, modern systems to search and analyze its own data, improve data management and privacy protection, and develop standardization of data to prevent valuable information from being inaccessible to interested parties [1]; therefore, be it

RESOLVED, That our AMA:
1) Discuss with the Department of Homeland Security, US Department of State subset Office to Monitor and Combat Trafficking in Persons, and other appropriate stakeholders the difficulties surrounding analysis and physician utilization of their data on US human trafficking; and
2) Recommend the formation of a national standardized human trafficking training program which could then be disseminated to physician, law enforcement, and other state organizations for improved training consistency and subsequent evaluation of competency; and be it further

RESOLVED, That our AMA encourage adoption and implementation of recommendations in The United States Government 2019 Trafficking in Persons (TIP) Report and similar government reports by:
1) Contributing to any feasible actionable target within our purview therein mentioned, especially but not limited to the challenges and advances in data collection and management in combating trafficking; and be it further
2) Explore physician initiatives to contribute to and support the development and improvement of existing international and national data management and collection initiatives including but not limited to: IOM Counter Trafficking Data Collaborative (CTDC), Victim Case Management System (VCMS), UNODC Human Trafficking Knowledge Portal and Polaris because collaboration with these organizations provides physicians with improved access to information, chronic management resources, interprofessional communication, etc.

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data: **H-406.998**
Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness;
(2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;
(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data;
(4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data;
(5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost

containment activities;
(6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and
(7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.

Physicians Response to Victims of Human Trafficking H-65.966
1. 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.
2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs. BOT Rep. 20, A-13Appended: Res. 313, A-15

Distribution and Display of Human Trafficking Aid Information in Public Places H-440.814
1. Our AMA policy is that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings.
2. Our AMA, through its website or internet presence, will provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same.
3. Our AMA urges the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings. Res. 023, A-19

Human Trafficking / Slavery Awareness D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.
Res. 015, A-18

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.
Res. 009, A-17

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: (MSS Res 32, I-14)
A. 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)

The Identification and Protection of Human Trafficking Victims: 515.008MSS
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

Legal Protection and Social Services for Commercially Sexually Exploited Youth: 60.023MSS

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])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 88
(I-19)

Introduced by: Mary Melati, Leslie Gailloud, University of Maryland School of Medicine; Anuradha Kanaparthi, Swathi Murthy, Rachana Raghupathy, Saima Wase, Northeast Ohio Medical University; Antara Afrin, Michigan State University College of Human Medicine; Kristan Baird, Uniformed Services University; Jack Gatti, Laura Pugh, Johns Hopkins University School of Medicine, Chloe Schockling, Katharine Hoffman, University of South Carolina School of Medicine Greenville; Pooja Nair, University of Missouri-Columbia School of Medicine.

Subject: Support Bleeding Control Training for Students in Grades 9-12

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, In the United States (U.S.) there are more than 60,000 deaths per year from hemorrhage[1]; and

Whereas, Uncontrolled bleeding is the leading cause of preventable death after a mass casualty event before medical assistance arrives[2]; and

Whereas, There were more than 38,000 deaths from firearms in 2016 in the U.S., and nearly 2,900 children and teens are shot and killed per year[3-4]; and

Whereas, There are more than 50 school shootings each year, resulting in injuries, fatalities, and trauma among U.S. children and adolescents[5-8]; and

Whereas, There have been 473 gun incidents on school grounds since 2013, resulting in 182 deaths and 365 injuries[9]; and

Whereas, U.S. schools have incorporated training in lockdown and active shooter drills to prepare students and staff for active shooter emergencies[10]; and

Whereas, The Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting reports that hemorrhage control during and after a mass casualty event would improve victim survival[11]; and

Whereas, The American College of Surgeons Committee on Trauma developed Stop the Bleed, a campaign to train, equip, and empower bystanders to help in a bleeding emergency before professional help arrives[12]; and

Whereas, The Department of Homeland Security (DHS) Science and Technology Directorate (S&T) and Federal Emergency Management Agency (FEMA) awarded funding to the National

Center for Disaster Medicine and Public Health (NCDMPH) to develop a School-Age Trauma Training program to teach students how to tend to traumatic injuries and control severe bleeding until first responders arrive on the scene[13]; and

Whereas, 39% of high school and college students reported previously being in situations where the Stop the Bleed content would have been helpful[14]; and

Whereas; The recognition of the importance of bystanders in saving lives have led to some states passing legislation requiring high school students be trained in CPR, AED, and Stop the Bleed prior to graduation[15-21]; and

Whereas, Non-medical providers who underwent Stop the Bleed training had increased knowledge about techniques of bleeding control and increased willingness and preparedness to assist in caring for a bleeding stranger[22-25]; and

Whereas, In June 14, 2016 our AMA declared gun violence a public health crisis and called for solutions[26]; and

Whereas, AMA policy H.145.990 supports increasing efforts to reduce pediatric firearm morbidity and mortality; and

Whereas, AMA policy H.130.935 supports training the public in essential techniques of bleeding control, but does not specify who should be trained; therefore be it

RESOLVED, that our AMA amend policy H-130.935 as follows:

Support for Hemorrhage Control Training, H-130.935
(1) Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
(2) Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
(3) Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in ~~schools,~~ places of employment, ~~and~~ public buildings~~.~~, and schools (including training for school personnel and students in grades 9-12).

Fiscal Note: TBD

Date Received: 09/20/2019

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RELEVANT AMA AND AMA-MSS POLICY

Support for Hemorrhage Control Training H-130.935
(1) Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
(2) Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
(3) Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

Standards of Care During a Mass Casualty Event H-130.933
(1) Our American Medical Association acknowledges that, in a mass casualty event, adjustments in the current health and medical care standards may be necessary to ensure that the care provided results in saving as many lives as possible.
(2) Our AMA will: (a) continue to participate with relevant stakeholders to disseminate guidance on the issue of the appropriate standard of care in a mass casualty event; (b) encourage state and specialty medical societies to work with state departments of health and other stakeholders as they develop guidance on allocating scarce resources and establishing the standard of care; and (c) encourage the creation of an adequate legal framework at the local, state, and federal levels for providing health and medical care in a mass casualty situation.

Community-Wide Training in Basic Life Support and First Aid H-130.952
Our AMA: (1) encourages education in (a) basic life support and first aid, and (b) effective interventions for reducing and preventing injuries and coronary heart disease;
(2) urges state and local medical societies to participate in the development and promotion of community programs for adults, children, businesses, community groups, and public servants to increase awareness of the potential benefits of training in basic life support and first aid and to increase public knowledge, confidence, and motivation for responding to serious, or potentially serious illness and injury situations; and
(3) encourages physicians to discuss with their patients: (a) how to recognize and respond to emergency situations; (b) proper utilization and activation of the local EMS system; (c) measures for reducing or eliminating potential risk factors for injuries and coronary heart disease; and (d) the availability and appropriateness of community programs in basic life support and first aid.

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Prevention of Firearm Accidents in Children H-145.990
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c)

encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that5 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:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) 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;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) 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;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) 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
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Handgun Violence 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: (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)

Preventing Fire-Arm Related Injury and Morbidity in Youth 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 89
(I-19)

Introduced by: Medical Student Section Governing Council

Subject: IOP Change to Clarify MSS Conflict Resolution Process

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

Whereas, The Medical Student Section (MSS) Governing Council (GC) is charged by the Internal Operating Procedures (IOPs) to "direct the programs and activities of the MSS"[1]; and

Whereas, In the event of a dispute, the IOPs provide codified language for internal mediation processes within the Section prior to elevation; and

Whereas, When disputes arise within Regions, Committees, or similar Section entities, it is the MSS GC's preference that processes internal to those entities resolve such disputes without further escalation; and

Whereas, There are instances in which disputes cannot be appropriately managed within the Region, Committee, or similar MSS entity in which they occur due to accusations involving their leadership or other conflicts of interest; and

Whereas, MSS Region or Committee leaders and their constituents may not be aware of what, if any, recourse is available to them should such a dispute arise; and

Whereas, We propose amending subsections 4.2 and 13.1.1 of the MSS IOPs to make explicit the MSS GC's oversight and ability to definitively resolve such matters when they arise within the Section's internal bodies; and

Whereas, The changes to the MSS IOPs proposed in this resolution will codify existing implicit functions of the GC, as demonstrated by section 13.1.1: "All disputes involving Regional Delegate or Alternate Delegate elections shall be resolved by the MSS Governing Council"[2]; and

Whereas, These proposed changes have been reviewed by internal AMA staff; therefore be it

RESOLVED, that our AMA-MSS revise the Medical Student Section IOPs by insertion and deletion as follows:

> 4.2 Authority. The Governing Council shall direct the programs and activities of the MSS <u>and make final determinations related to the Medical Student Section and the Medical Student Regions, consistent with the AMA Constitution and Bylaws</u>. During the interval between meetings of the MSS Assembly, the Governing Council shall act on behalf of the MSS in formulating decisions related to the development, administration, and implementation of student activities, programs, goals, and objectives. The MSS shall be notified at each National Meeting of actions taken by the Governing Council on its behalf.

13.1.1 All disputes involving Regional ~~Delegate or Alternate Delegate~~ elections shall be resolved by the MSS Governing Council.

Fiscal Note: TBD

Date Received: 09/20/2019

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1. American Medical Association Medical Student Section Internal Operating Procedures. ama-assn.org. https://www.ama-assn.org/system/files/2019-07/mss-iop-final.pdf. Published 2019. Accessed August 24, 2019.
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RELEVANT AMA AND AMA-MSS POLICY

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND MINORITY ISSUES COMMITTEE

MSS CEQM MIC Report A
(I-19)

Introduced by: MSS Committee on Economics and Quality in Medicine and Minority Issues Committee

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 2019 MSS Annual meeting, MSS Resolution 46 asked the AMA to support and advocate for federal laws that remove financial barriers to transplant recipients, a 2020 national taskforce for organ procurement that would be renewed every 20 years, to research a fiscal federal strategy that would cover annual transplant costs and to make amendments to 6.2.1. in the Code of Ethics and AMA existing policy H-370.982 that would alter statements to not regard immigration status. The A-19 Reference Committee referred MSS Resolution 46 for report. The MSS Assembly and Reference Committee specifically stated concerns over:

1) including criteria for having established a “physical presence” in the United States;
2) the resource intensive nature and feasibility of advocating and creating such a taskforce;
3) the limited feasibility of the AMA researching a fiscal federal strategy to cover annual transplantation costs given the AMA is not a body that commonly conducts such research;
4) the fact that the HOD cannot amend the AMA Ethical Opinion, and would have to be referred to the Council on Ethical and Judicial Affairs (CEJA).

Both the Reference Committee and Assembly agreed that this is an important resolution that could be strengthened through an assigned report. Specifically, we take note of the potential fiscal and political capital that would come of the asks.

BACKGROUND

Of the 11 million undocumented immigrants residing within the United States, an estimated 6,500 have end-stage renal disease (ESRD) requiring chronic dialysis.[1] Many of these patients, however, are unable to access appropriate care, largely due to financial barriers. The average cost of chronic hemodialysis per patient is $90,000/year and most patients with ESRD who are citizens are able to afford this through the 1972 Public Law 92–603 amendment to the Social Security Act that provides financial coverage to those who qualify for Social Security benefits.[2,3] Unfortunately, undocumented immigrants are excluded from these benefits and must rely on emergent-only hemodialysis, and only after they develop life-threatening metabolic disturbances.[4] The annual costs of these treatments range from $285,000 to $400,000 per patient.[5] Undocumented immigrants are able to receive emergent hemodialysis because the

1986 Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all states must provide federally funded emergency medical treatment. However, no federal, state, or local funds – including Medicaid, Medicare, and the Children's Health Insurance Program are available for maintenance therapy for undocumented immigrants with ESRD, as dictated by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act.[6,14,16]

The alternative treatment option for ESRD is kidney transplantation. Not only is this approach curative, it also has lower associated annual costs, averaging $39,939 per patient for HLA-compatible living donor transplantation.[7,8,17] Current ethical and legal guidelines dictate that medical need alone should determine how organs are allocated for transplant. However, only 1% of all kidney transplant recipients per year are non-citizens, which is grossly out of proportion to the 2-3% annual contribution to the donor organ pool made by this same population[9]. While organs may be allocated to undocumented immigrants, current policy excludes this patient population from receiving federal, state, and local funding to cover their transplantation and post-transplantation care.[10,11,14,20] This means that undocumented persons are not only unable to afford these potentially curative transplants, they are also unable to pay for costly post-transplant immunosuppressive medications, leading to graft failure over time. Consequently, thousands of patients with ESRD are forced to go without a potentially lifesaving transplant simply because of their legal status. These patients continue to receive costly dialysis treatment paid for by state emergency health care funds. It is evident, therefore, that there exists a glaring disparity in access to adequate long-term treatment options for undocumented persons with ESRD. Not only is there a moral imperative to advocate for the improved health outcomes of these persons, there is a financial benefit to improving access to kidney transplants. Since kidney transplantation is a curative and cost-effective long-term treatment option for ESRD, efforts should be made to facilitate access for undocumented persons.

While kidney transplantation is the most common organ transplant procedure, the lack of access to organs is even more complicated for other kinds of transplant since there are fewer non-surgical treatment options.[6,21] A recent study of liver transplant indicates that undocumented persons rarely get access to liver transplantation, and when they do, these patients are sicker, indicating a longer wait.[22,23] Undocumented persons' access to organ transplantation is further complicated by location. Access to transplantation varies by state, with almost a quarter of all liver transplants occurring at two transplant centers in California.[22, 23] Each transplant center gets to set their own rules for who can be added to the waiting list for an organ.[24] These rules, while also considering the patient's health and risk factors for transplant, also consider financial status, and without insurance, an undocumented patient is less likely to be considered a good candidate and is therefore less likely to get access to a organ transplant.[25]

As the biggest barrier to organ transplantation in this population remains financial in nature, it is important to continue research into feasible fiscal federal strategies that would cover annual transplant costs for undocumented and uninsured patients.

DISCUSSION

Organ procurement is an issue that affects over 100,000 people each year, and it is important to work towards equal access for all patients. Our AMA has also already shown support through previous policy for equal access in receiving transplants, regardless of citizenship status.

In regards to the first resolved clause of MSS Resolution 46, while the spirit of the clause is certainly in the interest of ensuring equality for organ transplant recipients, the phrase "physical presence in the U.S. prior to needing the organ" is vague and raises questions about what "physical presence" means and how it is confirmed. While the intention of ensuring that non-

citizens are not excluded from this process is clear and in line with previous AMA policy, such as H-370.990, there is concern that by keeping this phrase vague, “physical presence” is left open to interpretation and could possibly work against the overall goal of equal access. This phrase is repeated in resolved clause 4. In addition, in resolved clause 5, the language is not consistent with previous clauses, using the wording “as long as the person lives in the U.S.” and for clarity, having the same language here as was used in previous resolved clauses would be helpful. Overall, in order to ensure that non-citizens are considered viable recipients for organ transplants, the language needs more specificity.

In regards to the second resolved clause, the intention of keeping policies regarding organ procurement up to date is reasonable given our changing demographics and technologies. However, the choice to renew the task force every 20 years is not backed by any evidence or reasoning. A suggestion for specification is asking for a renewal every ten years since the national census is done every ten years, and this will provide standardized updates on demographic information, characteristics of minority populations, and immigration trends that can be considered accordingly by the task force. However, it is important to note that the AMA would not be the optimal body to establish this task force given the organization’s structure, but would be better off to support the establishment of this task force.

Similarly, regarding resolved clause 3, the AMA is not a body that routinely conducts primary research, and would be more equipped to support researching a federal fiscal strategy to cover the costs of organ transplantation and coverage of follow up care, including office visits and immunosuppressants.

Although the spirit and intention of fourth resolved clause is in line with current AMA policy, it is similarly out of scope, as changes to the code of ethics must be referred to the Council of Ethical and Judicial Affairs. In addition, it would be redundant to the asks of the fifth resolved clause.

The Minority Issues Committee did consider the suggested amendment by addition to the Code of Ethics 6.2.1 to be appropriate for an amendment by addition in H.370.982 in resolved clause 5. As written, this amendment strengthens the current policy, clarifying that a citizenship blind approach to organ transplantation is ethical in accordance to legal precedent. On the other hand, we believe that attempts to clarify the physical presence of an individual in the US may work against the goal of the resolution as previously stated.

It is within the scope of the AMA and the AMA-MSS to support the removal of financial barriers to access organ transplantation as it:

1) Improves equitable access to a benefit to a marginalized population to reduce health disparities, where the major hurdle to receiving a transplanted is financial cost.
2) Health care costs associated with emergent dialysis far outweigh the costs associated with routine hemodialysis and organ transplantation

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured or those who do not qualify for health care coverage regardless of a legally defined United States Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and

2) That the second resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA ~~promote and advocate~~ support the creation ~~for~~ of a 2020 national taskforce for organ procurement and transplant, that will be renewed every ~~20~~ 10 years to ~~access~~ assess the needs of the generation and account for changes in demographics and technology; and

3) That the third resolved clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a fiscal federal strategy to cover annual transplant costs in the U.S. for patients without or are ineligible for insurance distributed among the over 200 transplant centers in the U.S.; and

4) That the fifth resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

Ethical Considerations in the Allocation of Organ 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 without regard to a legally defined United States Citizenship and Immigration Service (USCIS).

5) That the fourth resolved be not adopted.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND COMMITTEE ON BIOETHICS AND HUMANITIES

MSS CGPH CBH Report A
(I-19)

Introduced by: MSS Committee on Global and Public Health and Committee on Bioethics and Humanities

Subject: A Resolution to Encourage Recovery Homes to Implement Evidence Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 2019 Annual AMA-MSS meeting, the authors of Resolution 52 asked the assembly to support expansion of medication assisted treatment (MAT) for opioid use disorder use in recovery homes. Your Reference Committee heard limited testimony on the resolution, all of which opposed the item as written, and decided to recommend against adoption of Resolution 52. In particular, testimony raised concerns about the unintended consequences of allowing patients to remain on all forms of MAT.

At the 2019 Annual meeting, Resolution 52 was extracted and those who stood up in favor testified that that MAT is the gold standard for treatment and is in line with current AMA policy. Those in opposition testified that the resolution was too prescriptive and could have unintended consequences. Other who supported Resolution 52 testified that similar policy had recently been passed by their state society. Your Government Relations Advocacy Fellow highlighted the work of the AMA Opioid Task Force and supported referral for study.

The Assembly voted to refer Resolution 52 to study, and the Committee on Global and Public Health and the Committee on Bioethics and Humanities conducted further research on the efficacy of MAT in the context of recovery homes. The resolved statement was as follows:

> RESOLVED, That our AMA urges policy changes at recovery homes to allow patients to remain on Medication Assisted Treatment as prescribed by a provider, including buprenorphine/naloxone combinations, without restrictions or mandatory tapering of doses.

Resolution 52 uses the term “medication assisted treatment (MAT)” to describe treatment of opioid use disorder using prescription partial opioid agonists and long-acting opioid antagonists. Many stakeholders have drawn attention to possible flaws that might exist with the term “MAT” and deter people from seeking treatment.[32,24] The term “MAT” misrepresents the principles of treatment for opioid use disorder (OUD). Evidence-based treatment for OUD emphasizes that the biological nature of addiction requires medical (e.g., pharmacotherapeutic) interventions, so describing medication as a secondary approach by using the term “Medication-Assisted

Treatment" is at odds with the medical community's approach to other chronic, relapsing disorders.[24] For these reasons, this report recommends amending the resolution to use the term "medication for opioid use disorder" (MOUD).

BACKGROUND

In the late 1980s and early 1990s, there was a strong push from numerous stakeholders, including the World Health Organization and *Scientific American,* for the medical community to address the undertreatment of severe and non-cancer related chronic pain. This led to the implementation of "pain as the fifth vital sign" by American Pain Society in 1995.[8] In response to this and several other campaigns, there was a major increase in the prescription and use of opioids including an increase in OxyContin prescriptions from 670,000 in 1997 to 6.2 million in 2002.[11] Opioid prescription continued to increase and hit a peak in 2011 and has had modest increases since 2014. Meanwhile, illicit opioid use, including newer synthetic fentanyl and heroin, has markedly increased, contributing to an increase in opioid related deaths. Currently the CDC reports that there are 44 deaths per day due to prescription opioids and 91 deaths per day from opioids of any source.[20]

Medications for Opioid Use Disorder (MOUD), alternatively known as Medication Assisted Treatment (MAT), include the full opioid agonist methadone, the partial opioid agonist buprenorphine, and the long-acting opioid antagonist naltrexone.[27] Buprenorphine is also sometimes prescribed in a combination dose with the short-acting opioid antagonist naloxone in order to prevent misuse of the drug.[34] When prescribed and used appropriately, these medications are safe and effective.[26]

Increased access to MOUD is one of the key evidence-based strategies recommended to treat people with OUD: all 3 medications are FDA approved for long-term management of OUD and have strong evidence supporting their efficacy.[28,16,31] Of these, methadone and buprenorphine are both listed by the World Health Organization as "essential medications".[26] The American Society of Addiction Medicine (ASAM) states that MOUD is the standard for treatment of OUD and that the decision of which medication to take should be made between the patient and their clinician.[12]

It is also recommended that psychosocial treatment be provided in addition to any pharmacological treatment because MOUD is often most effective when administered as part of a larger cognitive behavioral treatment approach.[27,12] When compared to placebo or no medication, individuals with OUD who are on MOUD have improved outcomes, longer treatment retention, and decreased opioid use.[6,15,33] For those receiving behavioral interventions alone, more than 80% return to opioid use.[6]

Recovery housing has been described by the National Association of Recovery Residences (NARR) as the provision of safe, healthy, and substance-free living environments for individuals that are recovering from substance abuse addiction.[19] There are multiple names commonly used for recovery residences such as sober living environments, sober homes, recovery homes, etc. that function similarly. They are a vital resource for individuals with OUD seeking a supportive housing environment after returning from institutions and treatment programs. Recovery homes are divided into four levels of support: peer-run (Level I), monitored (Level II), supervised (Level III), and service provider (Level IV). These levels are distinguished from one another by the services offered as well as their organizational structure. While they all provide

peer-to-peer recovery support, only residents in Level III and IV recovery homes have access to clinical services; Level IV are the only homes that provide clinical services on-site.[19]

Unlike “halfway houses”, recovery homes are financed through resident fees without restrictions on the duration of stay.[30] Since many do not provide formal treatment services, they are not monitored by state or federal licensing agencies, but best practice guidelines are available to guide programming. [23, 26, 30] Some states have taken action to implement or enhance formal oversight procedures to ensure consistency and quality between facilities, but federal and state policies regarding nondiscrimination towards individuals receiving MOUD and the availability of MOUD service with homes have failed to emerge.[30, 29] This has resulted in an absence of recovery home licensing requirements involving MOUD to guide home directors. Potential residents of homes often fall through the cracks when navigating the differing policies of multiple recovery homes.[18]

MOUD and recovery homes evolved out of separate communities, with recovery homes historically offering abstinence-based treatment. This difference, among others, has resulted in few recovery residences which adequately support persons receiving MOUD. Some programs, termed MOUD Recovery Residences, are open to residents who are undergoing all forms of MOUD, but many follow the classic Recovery Residence style, offering just abstinence-only treatment.[18] In general, there is an inverse relationship between emphasis on 12-step programs and implementation MOUD.[10]

Currently, most MOUD-Capable Recovery Residences use a mixed population approach where a portion of their residents are on MOUD while the rest are not. However, there is little research on the intersection of MOUD and recovery homes. A study by Majer et. al in 2018 suggests that individuals on MOUD often voluntarily discontinue their medication upon moving into recovery homes; however, no known study has evaluated the effect of a new resident using MOUD on roommates or housemates who have chosen to not be on MOUD.[18]

AMA Policy and Initiatives

The AMA has made several efforts to address the opioid epidemic, the most comprehensive of which was the creation of the AMA Opioid Task Force in 2014, made up of members of the AMA, the American Osteopathic Association, and 25 specialty and state medical societies. The Task Force’s initial 2015 guidelines for physicians focused on relevant topics such as 1) enhancing education and training on effective, evidence-based prescribing and treatment, and 2) supporting comprehensive, affordable, compassionate care for patients in pain and those with a substance use disorder.[4] According to the Task Force, an important component of education and treatment to address the epidemic, is training in and utilization of MOUD.[3]

From 2017-2019, there were a variety of new AMA health policies and directives focused on endorsing MOUD through education and initiatives that increased access, including for special populations like the incarcerated, those in inpatient settings, and pregnant and breastfeeding women, for example: Opiate Replacement Therapy Programs in Correctional Facilities H-430.987, Survey of Addiction Treatment Centers' Availability H-95.926, Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968, Medicaid Substance Use Disorder Coverage H-290.962, Treating Opioid Use Disorder in Hospitals D-95.967, Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972, and AMA Support for Breastfeeding H-245.982.[2]

During this period, the AMA-MSS called for increased federal regulation of outpatient addiction rehabilitation centers to ensure the provision of evidence-based care, and called attention to the physician's role in developing MOUD treatment for patients within drug courts. These policies included: Comprehensive Evidence-Based Drug Treatment in Prisons 95.006MSS, Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities 95.012MSS, Opposition to Lack of Evidence-Based Medicine in Drug Courts 95.014MSS, Opioid Abuse in Breastfeeding Mothers 100.017MSS, and Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder 120.013MSS.[2]

In May 2019, the AMA Opioid Task Force released its most recent recommendations, calling for policymakers to "remove barriers to treatment and to take additional steps to end the opioid epidemic."[5] At that time, a particular focus was placed on MOUD: "in the midst of an epidemic, and given the clear evidence in support of [MOUD] as a proven medical model to support recovery, save lives, reduce crime and improve quality of life, the AMA Opioid Task Force calls on all payers ... to end prior authorization and other unnecessary utilization management protocols for the treatment of opioid use disorder."[21] The guidelines go further to support increasing access to MOUD and other evidence-based treatment for pregnant and breastfeeding women with OUD, and supporting reforms in the civil and criminal justice system that help ensure access to high quality, evidence-based care for opioid use disorder, including medication-assisted treatment.

Overall, the gains made by the multi-factorial approach of the AMA and AMA-MSS in addressing the opioid epidemic have been substantial. In 2018 alone, 700,000 physicians completed courses on opioid prescribing, pain management, addiction, and related areas, while the number of physicians waivered to provide office-based MOUD reached 66,000.[5] Most importantly, from 2013-2018, opioid prescriptions decreased nationally by 33 percent, with every state in the nation seeing a decrease.[6] Many of these efforts to curb the epidemic were begun by the Task Force "prior to recent state legislative and federal efforts to restrict opioid prescribing or mandate specific education or training,"[3] highlighting the unique ability of the AMA to move the needle on this public health crisis.

DISCUSSION

The efficacy of methadone in treating opioid use disorder (OUD) was first established in 1965 and since then we have seen considerable evidence supporting this initial finding.[33] It is also clear that the structure of recovery residences is helpful in providing social support to people who are recovering from OUD and as well as services such as behavioral therapy. In fact, treatment programs that offer cognitive behavioral therapy, such as treatments based in recovery residences, are most effective when paired with medication for opioid use disorder (MOUD).[6,9] Patients who receive behavioral treatment alone have a 50% higher risk of relapse than those who also receive MOUD.[15] Ultimately, patients who are receiving care in recovery residences should not be excluded from receiving medication for OUD and should not be discriminated against for continuing their MOUD treatment.

While some residences have started to implement policies and practices aimed at supporting residents on MOUD, there has not been a consensus on best practices for supporting residents on MOUD during their stay in recovery homes. Where licensing requirements do exist for recovery homes, they are meant to regulate physical environment and business practices of recovery homes, but they do not address any aspects of medical care like the qualifications of staff or method of treatment. This lapse in regulatory requirements results in an environment

where patients with OUD are subject to substandard treatment and discrimination based on their use of MOUD.

Under no circumstances should patients be dissuaded from adhering to a treatment plan as prescribed by their physician. Patients should not have to choose between the social support found in recovery residences and the evidence-based effectiveness of MOUD. Moreover, establishments which are involved in the treatment of patients with OUD should not be in the business of coaxing people away from using MOUD. As an advocate for patients with OUD, our AMA should call upon all relevant parties to recognize the effectiveness and necessity of MOUD in the management of OUD.

CONCLUSION

It is the opinion of CBH and CGPH that medication for opioid use disorder (MOUD) should be incorporated into resident recovery programs across the United States. MOUD is the gold standard for treatment of opioid use disorder (OUD) and has been demonstrably effective in numerous contexts, including the context of recovery residences. Further, our AMA has been a leader in advocating for the widespread implementation of evidence-based treatment for OUD, and declaring a specific stance on MOUD in recovery residences is the natural next step in that leadership.

RECOMMENDATIONS

Your Committee on Bioethics and Humanities and Committee on Global and Public Health recommend that Resolution 52 be adopted as amended and the remainder of this report be filed:

> RESOLVED, That our AMA urges policy changes at recovery homes to ~~allow~~ protect patients ~~to remain on Medication Assisted Treatment~~ who use medication for opioid use disorder as prescribed by a provider, including buprenorphine/naloxone combinations, ~~without restrictions or mandatory tapering of doses~~ from discrimination against their admittance to recovery homes and related resident services.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CGPH Report A
(I-19)

Introduced by: MSS Committee on Global and Public Health

Subject: Improving the Health and Safety of Consensual Sex Workers

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At its Annual 2019 meeting, the AMA-MSS referred for study MSS Resolution 05 titled "Improving the Health and Safety of Consensual Sex Workers." The Resolved clauses were as follows:

> RESOLVED, That our AMA recognize the adverse health outcomes of criminalizing consensual sex work; and be it further
> RESOLVED, That our AMA support legislation that advances the sex work industry towards decriminalization and legalization.

Testimony on the Virtual Reference Committee was varied and divided. The Reference Committee recommended adoption of both Resolved clauses. The resolution was pulled from the consent calendar for debate on the floor. Consensus support was reached for Resolved clause 1; however, Resolved clause 2 remained contentious. MSS members were divided about the most appropriate stance for the AMA to support: legalization, full decriminalization, decriminalization only of the selling of sex, or remaining neutral. Ultimately, it was agreed that more detailed study was needed in respect to the second Resolved clause before taking policy position on this issue.

Your Governing Council assigned this report to the Committee on Global and Public Health (CGPH) with the following objective: To determine whether the MSS should ask the AMA to support legislation that advances the sex work industry towards decriminalization and legalization.

In this report, we begin by establishing current U.S. policy in regards to consensual sex work. We discuss relevant social and economic conditions that lead to entrance into the sex trade and its impacts on individual and public health. We then elaborate three major policy approaches to sex trade regulation: criminalization, full and partial decriminalization, and legalization. This is followed by our recommendations for the AMA-MSS on the optimal approach to U.S. prostitution policy in order to advance the health and safety of individuals who sell sex and of the general public, measured against what is known of the current sex industry.

BACKGROUND

Definitions

Understanding sex trafficking, survival sex, and consent and how each intersects with sex work is crucial in the development of a policy approach that supports the health and safety of those engaging in prostitution. Multiple terms may be applicable to a single individual.

- *Sex work* entails the provision for sexual services for money or goods.[1] It is further defined as the exchange of sexual services between consenting adults with the terms agreed between the seller and the buyer.[2] Sex work can be street-based "outdoor" prostitution, "indoor" prostitution (brothels, hotels, apartments), and more. This report discusses outdoor and indoor prostitution when referring to "sex work." The term "sex work" remains contentious due to debate surrounding the meaning of consent. Some who sell sex to survive may object to the term sex "work" as they do not identify their experience as a form of employment. However, "sex work" is commonly used in research and policy and thus will be used in this report.
- *Sex trafficking* is federally defined as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act".[3] This includes sex acts through force, fraud, or coercion regardless of citizenship or national origin. Notably, this does not include economic coercion or coercion due to addiction.
- *Survival sex* is the exchange of sexual activity for basic necessities such as shelter, food, or money.[4] Survival sex is considered a subset of "sex work" since it does not involve the force, fraud, or explicit coercion defined in sex trafficking.
- *Consent* is defined by the federal government as "a freely given agreement to the conduct at issue by a competent person. Lack of verbal or physical resistance does not constitute consent." Coercive sex- in the setting of economic, substance-related, or social vulnerability- often problematically falls under the term "consensual" sex work. Thus, consent in the realm of sex work falls on a spectrum, rather than a binary definition.[5,6,7]

Sex Industry in America

Prostitution is illegal across a majority of the United States, yet the underground commercial sex economy is one that generates multimillion dollar profits. Through the Tenth Amendment to the U.S. Constitution, regulation of prostitution is a power of the state government. Currently, Nevada is the only state to legalize sex work, allowing regulated brothels in eight counties. Five of these counties - Clark, Washoe, Carson City, Douglas, and Lincoln counties - allow all forms of prostitution. In spite of its legal status, however, the underground commercial sex economy remains a growing industry in major cities. Atlanta, GA, alone was estimated to have a sex trade worth $290 million in the year 2007.[8] This industry ranges from escort services to street prostitution to massage parlors and internet-based prostitution. The current legal approach to prostitution is criminalization; the act of selling sex is itself illegal in the United States, with the exception being the aforementioned counties in Nevada.

There is support for the decriminalization of sex work from multiple health and policy agencies, both internationally and in the United States. In 2014, the World Health Organization released a report detailing guidelines to prevent HIV spread in key populations. These guidelines include a recommendation to decriminalize sex work:[9]

> "Countries should work toward decriminalization of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers. The

police practice of using possession of condoms as evidence of sex work and grounds for arrest should be eliminated."

Corroborating studies from institutions such as Amnesty International and The Urban Institute call on governments worldwide to decriminalize sex work and institute changes to the policing of sex work.[2,8] A recent opinion piece in the AMA Journal of Ethics suggested the Nordic model of decriminalization, as discussed below, to be the most effective and ethical approach to addressing the issue of sex work and human rights violations.[10]

Prostitution and Health

Prostitution is associated with multiple mental and physical health consequences.[11-23] Field research in 9 countries demonstrated that 60-75% of women in prostitution have experienced sexual assault, 70-95% experienced physical assault, and 68% experienced PTSD to the extent of victims of state organized torture and of combat veterans seeking treatment.[11-13] 89% of women reported wanting to exit prostitution, but felt they had no other options.[11] Multiple studies have further demonstrated the mental health impacts of prostitution including increased rates of depression, PTSD, suicidality, dissociation, and substance abuse.[14-17] Mortality among those engaged in sex work is up to 40 times higher than the general population.[18,19] Additionally, the American Journal of Epidemiology reported a "workplace homicide rate" 51 times higher in prostitution than the next most dangerous occupation.[20]

Sex workers are at an increased risk of acquiring sexually transmitted infections (STIs). A street-based study on teen sex workers in Puerto Rico demonstrated increased rates of chlamydia, HIV, and syphillis.[21] Additionally, those engaged in sex work are at an increased risk of complications from STIs, such as pelvic inflammatory disease and ectopic pregnancies.[22] Lack of legal protection of sex workers' rights due to criminalization, combined with barriers to negotiating safe sex practices, contributes to the increased risk of sexually transmitted diseases. Research indicates that a majority of individuals in prostitution engage in regular use of drugs and alcohol. In a Chicago study of 222 women, 100% of the study participants used drugs and alcohol and a majority reported increasing drug use during time in the sex trade.[23]

Effects of Criminal Records from Sex Work

Research suggests that leaving the sex trade is a challenging process. Many sex workers have criminal records due to the criminalization of prostitution, which, in conjunction with a high rate of mental illness, poses a significant barrier in attaining the economic stability needed to exit the sex industry. Background checks demonstrating criminal charges commonly result in difficulty attaining or maintaining employment.[24,25]

Factors Contributing to Engagement in the Sex Industry

Research has consistently shown an association between childhood sexual violence and prostitution. The majority of individuals involved in prostitution experienced sexual trauma as children and later victimization as adults.[7,26,27] Minorities, especially African American women, begin selling sex or are first trafficked earlier than other women and comprise a disproportionate majority of those in the sex trade.[28] The global sex industry frequently recruits vulnerable women who may be coming from a foreign country in search of economic opportunity. Often they cannot speak the local language, hampering their ability to refuse to participate in any act or service.[29]

Those selling sex are overwhelmingly destitute and it is well understood that urgent financial need is the most frequent reason for entering the sex trade.[21,30] Economic marginalization

and homelessness greatly contributes to engagement in the sex industry, as sex can often be traded for money, food, shelter, or drugs.[6,31,32] Homelessness is one of the most common factors in the involvement of youth in survival sex.[31] In New York City, approximately one quarter of homeless youth reported trading sex, often for a place to stay.[32] Additionally, participation in the sex trade has been shown to correlate with prior engagement in child welfare, juvenile justice systems, and runaway homeless youth.[33]

The LGBTQ+ community is also disproportionately impacted by sexual exploitation and high-risk survival strategies such as survival sex. Homeless youth that identify as LGBTQ+ experience rates of survival sex 70% higher than their heterosexual counterparts.[34] Transgender individuals are more likely to sell sex due to socioeconomic and legal marginalization that leave few alternatives to earning a livelihood.[35]

Further, undocumented immigrants are at increased risk of engaging in the sex trade due to economic constraints, however no reports exist currently to accurately depict these numbers. When arrested with prostitution charges, many immigrants may become ineligible for documented status and some have been deported following prostitution arrests.[36]

Buyers in the Sex Industry

In considering the impact of various policy approaches to sex work, discussion should include an understanding of the sex acts consensually purchased and the perspectives of buyers considered in the setting of full decriminalization. Consensual sexual acts purchased may include oral, anal, or vaginal penetration with penis or an object, defecation, urination, choking, biting, hair pulling, physical restraints, or use of intimidating words and gestures.[37]

Research demonstrates attitudes and behaviors of the buying population may reflect violence and disregard for the safety and wellbeing of sex workers. In a 2008 study of Chicago sex buyers, 43% of buyers stated that if men pay for sex, women should do anything they are asked and 19% admitted to raping a woman.[38,39] A study of Boston sex buyers reported that 37% of men stated that once sex is paid for, women are obligated to do anything asked.[27] Sex buyers indicate that they buy sex because it is easy to buy and has few consequences.[40]

Policy Approaches to Prostitution

We examined the results of different approaches to prostitution policy in various countries to determine the potential implications of policy change.

Criminalization

The criminalization model, followed by most of the United States, seeks to prosecute any individual involved in the buying or selling of sex, including, but not limited to, sex workers, buyers or “johns”, third party sellers, and pimps. Criminalization of people who sell sex has been associated with higher rates of STIs, lower rates of medical care access and police intervention in cases of sexual assault, and higher rates of violence against individuals selling sex.[13,14,15,16]

Decriminalization

The decriminalization model promotes the removal of criminal penalties for consensual sex work, considering it neither a crime nor licensable activity.[6] Decriminalization of sex work applies to laws that criminalize consensual adult sex work and does not repeal laws against trafficking, child sexual exploitation, or other forms of violence.[41] Decriminalization may be partial, eliminating criminialization of the

sale of sex while maintaining the purchase of sex as a crime, or full, eliminating criminalization of both sellers and buyers.

The Nordic Model, also known as the Equality Model, is the most widely-followed system of partial decriminalization. The Nordic Model was first created in Sweden following multiple years of study by a government commission and input from feminist groups, survivors of sex trafficking, people currently involved in the sex industry, and the public.[6] In the Nordic Model, the selling of sex is decriminalized, while buying sex, acting as a third-party profiteer, and brothel-owning are criminalized. People currently selling sex are offered voluntary participation in social services, and people found to be buying sex are offered voluntary participation programs to help them stop buying sex.[6]

Country or State	**Model of Decriminalization**	**Outcomes**
Sweden	Partial decriminalization: The Nordic Model (instituted in 1999)	Three years after the enactment of this legislation, prostitution in Sweden dropped 30-50%, and the number of men buying sex dropped from 13.6% to 7.8%.[6] The number of individuals trafficked into Sweden is significantly lower than those of surrounding nations.[6,42,43]
Norway, Iceland, France, Ireland, Northern Ireland, Canada, and Israel	Partial decriminalization: The Equality Model	Similar results to those seen for Sweden, as described above.[30,44]
Denmark	Full decriminalization of buying and selling sex (instituted in 1999)	Human trafficking into Denmark increased following these legislative changes. Human trafficking rates per population size in Denmark are four to five times higher than those in Sweden.[6,42]
Rhode Island	Decriminalization of the “indoor” buying and selling of sex (in place 2003-2009)	The indoor prostitution market increased in size. Data showed a 31% decrease in reported rape offenses and 39% decrease in cases of female gonorrhea during this time.[45]

Legalization

This model codifies the selling of sex as a legal activity with no criminal consequences for sex workers, buyers or “johns”, third party sellers, or “pimps” who operate within the limits defined by local law. It is important to note that legalization does not apply to human trafficking or child protection laws. Two large studies, examining 31 and 150 countries, found trafficking of persons for commercial sexual exploitation to be most prevalent in countries in which prostitution is legal and lowest in countries in which prostitution or sex buying is illegal.[42,43] Legalization results in increased demand, which outstrips the number of individuals willing or available.[46] This then leads to an increase in trafficking to meet the demand. These numbers can

be illustrated by the markedly higher rates of trafficking in the city of Amsterdam (4,000 persons trafficked each year, or one person for every 203 residents) as compared to the country of Sweden (500 persons trafficked each year, or one person for every 19,200 residents) which implemented partial decriminalization.[6]

Country	Model of Legalization	Outcomes
The Netherlands	Selling, buying, and brothel-owning are legal (instituted in 2000)	Widespread exploitation, trafficking and abuse of sex workers. 60-70% of women in the sex industry were reported to be coerced by organized criminal groups.[6]
Germany	Selling, buying, and brothel-owning are legal (instituted in 2002)	Increased trafficking of women from impoverished Eastern European countries who are coerced into sex work and forced to remain in prostitution.[29,46,47]
Turkey	Selling and buying of sex are legal only at licensed, state-regulated brothels (instituted in 1923)	Closing of brothels and refusal to issue licenses in a conservative political climate as well as economic strife has led many women to turn towards survival sex outside of brothels.[49]
Peru, Taiwan, Bangladesh, among others	Various forms of legalization	Similar increases in trafficking, abuse, and coercion of women in sex work to those described for other countries.[50-53]

DISCUSSION

Engagement in prostitution is correlated with multiple socioeconomic factors including poverty, immigration status, and homelessness. The high burden of mental, physical, and emotional harm for those engaging in the sex industry has been thoroughly documented and consistent. Reports of widespread violence against those who sell sex continue to emerge, with estimates of lifetime violence ranging from 45% to 75% and workplace homicide rates exceedingly high in comparison to traditionally high-risk professions.[54,55] Data shows increased rates of mental health disorders, such as post-traumatic stress disorder, depression, dissociation, and substance use disorder.[7,54] Evidence has also shown a link between policing practices, such as coercion, arrest, raids, and violence with increases in the rates of physical and sexual violence against sex workers.[54] Current U.S. policy criminalizing the sale of sex exacerbates these negative consequences.

There are several known policy approaches to prostitution and sex work that have been established across the world. We describe these policy approaches and their practical implementation in case studies of signatory countries below.

Criminalization

Criminalization, as practiced in the U.S., is associated with a lower rate of trafficking compared to legalization, but not when compared to partial decriminalization.[6,42] Yet, significant disadvantages to this approach have been shown. Systems of criminalization have been shown to result in decreased protection and reach of services for sex workers as

well as persecution of individuals who may be engaging in survival sex. Regional studies conducted on sex workers globally demonstrate police are among the main perpetrators of physical and emotional violence against sex workers.[55] This has been shown to result in adaptations to avoid arrest, such as moving to more isolated conditions and not reporting physical attacks and accessing medical treatment. In the U.S. this has resulted in fewer women carrying condoms due to fear of police harassment.[56] The negative consequences of criminalization on the personal autonomy, privacy, safety, health, economic mobility and opportunity for exit of sex workers has been demonstrated consistently.[18-20,24,25]

Partial Decriminalization: The Equality Model

Partial decriminalization is associated with a markedly lower rate of human trafficking as compared with legalization and full decriminalization, with no rise in comparison to criminalization.[6] Transition from criminalization to the decriminalization of the sale of sex in the Equality Model in Sweden was shown to lower demand and overall rates of prostitution, and it led to a comparatively lower number of persons trafficked compared to surrounding nations using other policy systems.[6,48] Though decriminalization will not eliminate all the risks of sex work, it will empower sex workers to self-organize and collaborate with law enforcement.[57] A critique of this policy is that it may limit the number of clients available to those who may have chosen to freely participate in sex work.

Full Decriminalization

The temporary decriminalization of indoor prostitution in Rhode Island increased size of the market, however it also led to a significant reduction in reported rape and cases of gonorrhea.[45] This approach has also resulted in lower rates of STIs among the general population. Advocates for full decriminalization, such as Amnesty International, note the reduction in sexually transmitted diseases, including HIV, seen in nations implementing full decriminalization.[2] However, their report focuses largely on the effects of prostitution policy on STI rates and does not address the psychological effects on sellers and buyers in the industry.[2] Full decriminalization of the sex industry expands market forces that attract organized crime, disproportionately affecting vulnerable individuals.[6] Full decriminalization, as implemented in Denmark, has been associated with an increase in trafficking, and it has not been associated with decreased violence against sellers in the industry.[6]

Full legalization

Full legalization of prostitution or sex work allows for the licensure of brothels or individual sex workers and can improve public health tracking. Legalization would allow governmental regulations requiring regular health evaluations of sex workers, potentially reducing the spread of STIs[6]. Legalization also allows for unionizing of sex workers. Legalization of sex work would allow for taxation of this industry, adding to a country's GDP. However, legalization of prostitution has been shown to lead to an increase in human trafficking and organized crime.[42,43] Though the potential for sex workers to form unions exists, unions are rare, small, and not utilized by the majority of workers. Meanwhile, sex buyers and brothel owners in the Netherlands have successfully formed organizations and unions that have advocated for their interests.[6] Furthermore, regulations enacted in states that have legalized sex work seem designed to protect buyers rather than to protect sellers of sex. Nevada, for example, requires sex workers be tested every three months for STIs[58] while sex buyers need not show any documentation of their STI screening, despite the fact that some STIs can be asymptomatic in women but can cause infertility. While legalization of sex work makes it a taxable industry, it may also provide an incentive to deregulate markets to increase tax revenue at the expense of activity like trafficking.[59] Additionally, legalization of

sex work would continue to criminalize and penalize undocumented people engaged in survival sex, since they are not legally eligible for work in the United States.

CONCLUSION

Prostitution has been associated with severe mental and physical health consequences. Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population. Given the overwhelmingly positive effects of this model, in comparison to other policy approaches described toward prostitution, we recommend decriminalizing individuals who sell sex while maintaining criminalization of buying sex and of third parties profiting from sex work. Research indicates a large number of upstream issues, such as poverty and inequality of opportunities, to lead vulnerable and marginalized populations to enter prostitution. A number of factors, such as substance use disorders, criminal records, and trauma acquired from involvement in the sex trade, make it difficult to leave the sex industry. We recommend a number of evidence-based avenues to prevent or ameliorate the effects of these factors. The Equality Model, as described above, offers several unique advantages that make it preferable. Ongoing support for this policy should be contingent upon positive results, making additional research into outcomes necessary.

RECOMMENDATIONS

Your Committee on Global and Public Health recommends that the following Resolved clauses be adopted in lieu of the proposed Resolved clause, and the remainder of this report be filed:

RESOLVED, That our AMA support legislation that decriminalizes individuals who are solicited for sex in exchange for money or goods; and be it further

RESOLVED, That our AMA advocate against legislation that decriminalizes sex buying and third-party promoters and profiteers; and be it further

RESOLVED, That our AMA recognize that barriers to education, housing, and economic opportunities contribute to engagement in the sex industry; and be it further

RESOLVED, That our AMA support legislation that provides resources and support for vulnerable individuals to prevent the necessity of entering the sex industry as well as to support those choosing to exit the sex industry; and be it further

RESOLVED, That our AMA support expunging the criminal records of those previously convicted of sex work, including trafficking survivors; and be it further

RESOLVED, That our AMA support legislation promoting research on the long-term health, including mental health, impacts of decriminalization of the sex trade.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY & COMMITTEE ON BIOETHICS & HUMANITIES

MSS CHIT CBH REPORT A
(I-19)

Introduced by: MSS Committee on Health Information Technology and MSS Committee on Bioethics and Humanities

Subject: Implementing a Standardized Patient Flag System in the Electronic Medical Record

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 2019 Annual meeting, the AMA-MSS referred the MSS Resolution 35- "Implementing a Standardized Patient Flag System in the Electronic Medical Record" which states the following:

> RESOLVED, That our AMA encourages all healthcare facilities to implement a standardized patient flag system in electronic medical records in order to reduce workplace violence.

Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Health Information Technologies (CHIT). In anticipation of potential social and ethical considerations related to labeling patients, CHIT invited your MSS Committee on Bioethics & Humanities (CBH) to contribute to this report. Your CHIT and CBH ("the authors") studied the state of workplace violence in healthcare, in addition to existing guidelines and initiatives meant to address this issue. The authors examined the nature, implementation, and outcomes of existing EHR flagging systems. Finally, the authors looked into existing AMA policy and initiatives that already address the spirit of this resolution and determined the need for more specific policy.

BACKGROUND

Current State of Workplace Violence in Healthcare

Evidence consistently suggests that incidents of workplace violence are more prevalent in the medical field compared to other workplaces in the United States. According to the Occupational Safety and Health Administration (OSHA), a healthcare worker was four times more likely than workers in other fields to be involved in a serious violent incident between 2002 and 2013. Of the roughly 24,000 annual incidents of violent acts directed towards a person at work from 2011 to 2013, nearly 75% occurred in healthcare settings.[1] In a 2018 national survey, 47% of 3,539 emergency medicine physicians reported being physically assaulted while working.[2] In addition to the immediate consequences of being involved in an incident of violence, these incidents

contribute to increased rates of missed workdays, burnout, and job dissatisfaction, along with decreased productivity and feelings of safety among staff members.[1]

The increased risk of workplace violence in the medical field is clear. Yet, a more subtle but equally serious aspect of this issue is the culture that allows for violence to continue. Among victims of workplace violence in health care settings, only 30% of nurses and 26% of physicians go on to report the incident.[1] In a study of Minnesota Nurses, only 27% perceived violence to be a problem at work.[3] The evidence of violence and the perception of those at risk are in conflict. Health care workers are unaware that episodes of workplace violence are a major problem. As a result, when these episodes occur, there is significant underreporting. Violent incidents are estimated to be three times the number reported by the Bureau of Labor Statistics, which does not include verbal incidents.[1]

Of the incidents that are reported, many perpetrators against healthcare workers have common characteristics. In most cases, the patient is suffering from a change in mental status due to a variety of underlying conditions. This most commonly includes: dementia, delirium, substance intoxication, or decompensated mental illness.[1] Half of emergency physicians reported that at least half of all assaults are committed by people believed to be seeking drugs or under the influence of drugs or alcohol.[2] However, many extrinsic factors have been identified that are unrelated to the nature and behavior of patients themselves.[4] These include unusually long wait times or crowding, lack of training for security and staff, and domestic disputes among patients or visitors. While some factors may make some patients more prone to violent behavior, there are many outside variables that may influence a patient's behavior on a day-to-day basis and are not applicable to every clinical encounter that a patient has.

Current State of Workplace Safety Promotion

The Joint Commission, OSHA, and other organizations responsible for promoting and enforcing standards in healthcare facilities and workplaces keep safety in mind when conducting their reviews. Some organizations, such as the International Association for Healthcare Security & Safety (IAHSS), lists a flagging system as one of many recommendations to consider.[5] Tools to prevent violence are also being adopted at healthcare facilities around the country. Perhaps most notably, The Veterans Health Administration (VHA) uses a patient flag system.[6] Other health systems have also adopted this tool, including University of Iowa Hospitals and Clinics, Aurora Health Care, and Brigham and Women's Faulkner Hospital.[7] The VHA's policy and procedures are well documented and provide a clear example of how a standard Patient Record Flag (PRF) system could be organized and maintained. These policies include restricting PRF entry to Chiefs of Staff, establishing clearly written definitions and criteria for entry of a PRF, recognizing PRFs are purely advisory and serve to enhance safety and the care of patients, recommending PRFs be viewed prior to patient encounters, including a brief summary of the rationale behind each PRF, and establishing a regular review process of each PRF.[6]

Aside from these examples, flagging systems are still rare and the concept seems to have a small place in the context of larger safety initiatives. The AMA, American Hospital Association, Emergency Nurses Association, and many other professional organizations have both separate and cooperative campaigns to identify the issue of workplace violence and promote cultures of safety. Generally, these campaigns primarily focus on recognizing and reporting violence, and secondarily offer safety strategies. The National Institute for Occupational Safety and Health (NIOSH) lists a flagging system as just one of twelve different preventative strategies to consider. Studies on the implementation of flagging systems are rare and its effect on reducing incidents of violence is still questionable.[7] However, safety interventions in general, and the culture change that accompanies them have been shown to be effective.[9] There is a wide range

of possible strategies to promote safety in the healthcare setting. Adopting several as a part of a larger culture change will most likely improve conditions in a particular facility or system.[8]

Social Impact of EHR Flagging

There are a few early adopters of the EHR flagging system. These hospitals can serve as case studies to better understand the social impact of EHR flagging. Negative outcomes, as a result of a flagging system, are difficult to quantify since they are related to interpersonal engagement. There are little to no published examples of patients being subjected to stigma or diminished quality of care as a result of flagging systems. Anecdotal evidence seems to suggest that patient care and working environments could both be improved by flagging systems. This example of a typically compliant and well-mannered patient, who becomes aggressive only under certain situations, supports this possibility:

> "When lab technicians approached the patient with a needle, the patient lashed out blindly in abject panic and twice unintentionally caused injury. Understanding the trigger allowed the patient's caregivers to come up with a plan for preparation and support when blood work was needed. The flag system was used to warn anyone who might need to approach the patient with a needle that a plan needed to be followed to ensure everyone's safety."[10]

Of the anecdotal evidence that exists, EHR flagging appears to maintain or improve patient care and provider safety, while avoiding patient stigma.

Existing AMA Policy on Workplace Violence

This section briefly introduces existing AMA policies that are directly pertinent to addressing workplace violence. Policies from the AMA House of Delegates (HOD), Directives from the HOD, and opinions from the Code of Medical Ethics were considered for inclusion.

The AMA identifies the issue of workplace violence in healthcare and is committed to addressing it with D-515.983:

> "Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training."

AMA policy is broad and flexible in its pursuit of workplace safety strategies. The AMA is committed to supporting other applicable stakeholders in their capacity to promote a culture of safety. Moreover, the AMA will work with these partners to identify and share effective interventions to achieve this goal. No one intervention or collection of interventions is explicitly stated. Instead, the emphasis is that any intervention be deemed effective and worth disseminating.

In addition to promoting effective safety strategies as they are identified, the AMA focuses on federal regulations and investment in H-515.957:

> "Our AMA (1) encourages the Occupational Safety and Health Administration to develop and enforce a standard addressing workplace violence prevention in health care and social service industries; (2) encourages Congress to provide additional funding to the

National Institute for Occupational Safety and Health to further evaluate programs and policies to prevent violence against health care workers"

This policy goes a step further than D-515.983, by actively supporting increased investment into the discovery and standardization of new safety measures by the federal government and its applicable agencies. Together, these two policies identify a legitimate problem within the healthcare industry, commit the AMA to advancing interventions and methods that will address workplace violence, and call upon federal stakeholders to invest in solutions. Without identifying any specific intervention, the AMA stays focused on the goal and not any particular method. These policies, then, can be applied indefinitely and help elevate many interventions. This potentially includes by is certainly not limited to an EHR flagging system.[8]

DISCUSSION

While conducting this report, the authors had several main concerns: What is the scope of the issue of workplace violence in healthcare? How is the issue being addressed currently? What does existing policy already empower the AMA to do? Is EHR flagging an ethical method? Is EHR flagging an effective method? Would it be reasonable to support a standard EHR flagging system?

The authors are convinced that workplace violence in the healthcare setting is pervasive and requires significant investment from all pertinent stakeholders and government agencies to address it. It is also clear that many professional, private, and government organizations have come to the same conclusion and are now paying close attention to the issue. Moreover, they are making serious attempts to expose the issue of violence and promote a culture change throughout the industry. Given the dissonance between the scale of the issue and the awareness of those at risk, embracing a culture change is a critical first step for healthcare systems. As a part of that culture change, there are a variety of potential interventions that can be adopted to promote workplace safety. These recommendations do not always, but occasionally, include a flagging system. There is a growing list of examples of flagging systems in healthcare facilities. However, adoption is relatively slow and met with skepticism, mainly due to concerns of patient profiling and the potential negative impacts of such.

The authors sought to understand the implications that a flagging system would have on the patient-provider relationship. We recognized that workers in emergency departments are frequently exposed to abuse by patients, and that patient flagging is an attempt to create a safer work environment. However, we were concerned, like many seem to be, that a flagging system would lead to stigma against "flagged" patients. To evaluate the potential for these negative consequences, we sought out evidence from hospital systems that already have flagging systems in place.

The examples we found highlight how flags on patient records may be used to improve care for the patient while simultaneously protecting the safety of workers. In a thoughtful and patient-centered flagging system, flags are not arbitrarily assigned when a provider does not get along with a patient, for example. Flags are only applied after identifying a behavior that poses a threat to staff and a plan can be developed to mitigate aggressive behaviors. This distinction is crucial when educating staff about how to implement a flagging system.[10]

Considering the possibility of added stigma to the patient-provider dynamic, proponents of flagging claim that these systems actually limit stigma by specifically detailing the nature of a patient's risk. If a patient has a mental health diagnosis that is associated with aggression, staff

might make assumptions and avoid them. If that patient's chart was flagged and included a care plan to address potential triggers, providers might be more comfortable and more effective care givers. In this way, flags are less about warning and more about educating a provider on how to best interact with a patient. In all cases, alerts should make it clear that flags do not indicate that patients should be avoided.[10]

Flagging systems also bring about concerns regarding patient privacy. If flags are readily displayed in and around a patient's room, there is a chance that private information might be compromised. However, when producing a plan to avoid triggers and keep workers out of harm's way, communicating details of specific medical information may not be necessary.[11]

There is potential value in adopting a flagging system, concerns of labeling patients can be thoughtfully addressed, and there may even be an opportunity to decrease patient profiling. However, the usefulness of this approach on its own is mostly anecdotally supported. Moreover, most institutions that adopt this system concurrently adopt other systems within a larger safety initiative. The authors are optimistic about the prospects of flagging systems, but it seems clear that it is not a blanket fix and should not be considered as a stand-alone measure. Rather, medical facilities should consider developing a flagging system as they see fit and as the administrative resources are available to implement it responsibly.

Creating a standard system for patient flagging within a healthcare group, that is linked with similar EHR systems, is possible. However, there are difficulties and nuances that require consideration. For more objective criteria, such as a patient's need for isolation, there has been successful implementation of a system that would appropriately flag any patient who meets the criteria. Implementation of this system required coordination with an electronic lab managing system in addition to significant human collaboration.[12] In addition to specific technical hurdles, flagging potential safety risks is more subjective than flagging a patient for isolation.

Because of the subjective nature of provider safety flagging, it is appropriate for there to be a committee of decision makers, all of whom are not directly involved in any incident. Moreover, it is appropriate for there to be the availability of an appeals process for patients who have been flagged. For this process to occur, patients have to first be made aware that they are flagged and that such a process exists. In 26 applicable EHRs that were studied, the Inspector General for Healthcare Inspections found that 7 had no evidence of clinicians notifying patients about being flagged. In 24 of the 26 EHRs studied, there was no evidence of clinicians informing patients of the right to appeal the flagging.[13] While the authors believe that a flagging system can be implemented successfully and ethically, there is a significant amount of administrative effort needed. Unfortunately, in the medical systems where EHR flagging exists, the administrative element seems to fall a bit short, at least regarding an appropriate appellate process.

CONCLUSION

The authors believe that an EHR flagging system is a legitimate option for medical systems to consider in their pursuit of a safer work environment. However, adopting one would be a significant investment in time and resources beyond the technical ability to flag a chart. The necessary administrative infrastructure is significant. While it is possible for a flagging system to be maintained ethically and productively, the lack of a deliberate process poses some risk of suboptimal outcomes. Because of this, the authors cannot support the recommendation of a standard EHR flagging system at this time. However, the authors would support an initiative to further assess this intervention's effectiveness and have no essential concerns with it as a

concept. Because existing AMA policy supports investment in the discovery and study of interventions to reduce violence in healthcare, and is prepared to advocate for interventions that have been deemed effective, the authors are confident that there is an avenue for EHR flagging systems to be supported by the AMA, provided that existing examples of these systems show positive results.

RECOMMENDATIONS

Your CHIT and CBH recommend that Resolution 35 not be adopted and the remainder of this report is filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report A
(I-19)

Introduced by: MSS Committee on Medical Education

Subject: Requiring Blinded Review of Medical Student Performance

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At its 2017 Interim Meeting, the AMA-MSS Assembly referred for study MSS Resolution 93, "Requiring Blinded Review of Medical Student Performance," which states the following:

> RESOLVED, That our AMA advocate that all reviews of medical student professionalism and academic performance be conducted in a blinded manner; and be it further
>
> RESOLVED, That our AMA send a letter to the Liaison Committee on Medical Education (LCME) advocating that blinded review of medical students be required of all LCME-accredited medical schools.

The AMA-MSS Assembly supported the spirit of the resolution but noted the concerns (related to limited avenues of action brought by the previous report) of the I-17 Reference Committee and referred the resolution for study to the Committee on Medical Education (CME). The resulting report at I-18 asked our AMA-MSS to formally support current policy. The AMA-MSS Assembly again supported the spirit of the report, but noted the concerns of the I-18 Reference Committee and re-referred the report for study. Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Medical Education (CME). Your CME performed an analysis of pertinent policies on review boards so that the MSS could account for a broad scope of medical schools and acknowledge varied perspectives, including those outside of the AMA-MSS.

This report begins with an overview of professionalism and academic performance assessments. It then examines the resolved clauses of Resolution 93 (I-17) and discusses pertinent implications for each of these recommendations. Each section contains a summary that recapitulates CME's reasoning for supporting or not supporting the proposals in Resolution 93. Your CME then provides its own amendments to Resolution 93, the primary goal of which is to emphasize fair evaluation of medical students.

BACKGROUND

An overview of medical professionalism and the assessment thereof

Medical professionalism is a core component in patient care. It's been shown to have high association with improvements in physician-patient relationships, patient satisfaction, health care professionals' career satisfaction, and even healthcare outcomes.[1–5] Tools to assess professionalism in the medical

field started developing thirty years ago and in 1986 the Liaison Committee on Medical Education (LCME) created a requirement for more allopathic medical schools to include professionalism training in the curriculum.[1,6]

Professionalism is taught throughout undergraduate medical education (UME), classically in didactic and simulated scenarios during the first two years of medical school and through clerkship experiences during third and fourth years of medical school. There is no one standardized method for teaching the complex and evolving topic of medical education.[6]

Many different instruments have been developed to assess medical professionalism, with no clear method being the most superior. However, assessment tools incorporating student feedback have shown to be more effective in evaluating the student's professionalism as well as the student experience (such as clerkship rotations).[1,6]

The LCME states in their "Standards for Accreditation" that all allopathic schools must have a variety of measures employed, one of which is direct observation to assess student achievements in topics including professionalism and appropriate behavior. Furthermore, all interactions between medical students and patients must be under supervision. They also instruct schools to create a system to receive feedback from students and a reporting system for student mistreatment and appeals. Lastly, no school can function in any capacity in a discriminatory manner.[7]

The Commission on Osteopathic College Accreditation (COCA) states similar requirements for osteopathic medical schools in regards to direct student observation, supervision, reporting systems for mistreatment and appeals, and creating a health learning environment.[8]

AMA's Stance on professionalism training and assessment in UME

The AMA House of Delegates has passed several resolutions regarding medical student professionalism over the years: H-295.886, D-295.984, H-295.995, H-295.900.

Briefly, the above policies will be discussed:

Policy H-295.886 asks our AMA to support regular assessments of student professionalism throughout UME to the purpose of creating valuable feedback and improving the students' performance in future assessments.

Policy D-295.984 encourages the sharing of professionalism learning and assessment tools between medical schools. It also asks our AMA to work with relevant stakeholders to collect this information and disseminate it.

Policy H-295.955 introduces a Code of Behavior covering the teacher-learner relationship and possible destructive characteristics to avoid and urges medical schools to follow. It also recommends medical schools "delineate procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, and (d) sanctions."

Policy H-295.900 addressed an effective and safe learning environment for teachers and medical students. It also takes measures to protect students who report incidents of mistreatment.

DISCUSSION

Graded and scored reviews of students

Standards are set forth by LCME and COCA and must be followed by all medical schools in the United States to have full accreditation. Both organizations state direct observation is needed for assessment of medical students. Additionally, both sets of standards require supervision of medical students during interactions with patients. Clinical experience and assessments are imperative for medical student training and improvement and will continue to be a core of UME. Failure to comply with the appropriate standards would result in a school's de-accreditation and risk the future career of the attending students.[7,8]

There is little information concerning the practices of US medical schools and their policies on how student grades for practicals (e.g. Objective Structured Clinical Exams[OSCEs], clinical evaluations, etc.) and written exams are handled. As such, we reason that it cannot be determined if blinded review has been implemented in a vast majority of US medical schools and therefore make the assumption that implicit bias may currently be affecting the medical education of many students.

On the topic of written examinations, we have agreed that the best form of implementation is through a system not unlike those implemented in a double-blinded study: exams would be deidentified, graded, and then reidentified to their respective students. Student grades would be available to relevant administration members after grading in order to assist students who may be struggling in their classes.

The topic of practical examinations remains a more fickle subject; in these examinations, it is functionally impossible to fully de-identify a student when accreditation protocol requires that medical students be directly observed during practical examination and directly supervised during clinical encounters. To limit implicit bias, we believe the diversification of faculty graders to be a reasonable compromise. Although we recognize that we cannot completely remove implicit bias, it can be blunted or functionally negated by having multiple perspectives on the same student's performance. Additionally, acknowledgement and mitigation of implicit bias or discriminatory training also hold potential to improve the outcome of practical evaluations.[9–14]

Disciplinary and professionalism review of students

In regard to disciplinary procedures, we discussed that a completely blinded process would have unintended negative consequences to the students. We examined the disciplinary procedures of many institutions of higher education and none provided specific insight into the policies of disciplinary hearings when it comes to professional infractions.

However, we did find evidence from one university that provided a stepwise approach to professional infractions in which the severity of punishment would be incrementally increased based on prior infractions. In this model, a student's behavior is taken in context of their overall professional record. Thus, first time offenders are buffered from more severe consequences. A similar disciplinary procedure is also taken in legal courts of law.

We hypothesized that since the majority of professional infractions by medical students are one-time mishaps, a blinded disciplinary process would end up harming the student as their previous history would not be considered and the same penalty would be levied as someone with multiple infractions. Thus, in regard to disciplinary procedures, we believe that a blinded review process would be detrimental for students.

Although we disagree with a blinded disciplinary review process, we do believe there should be an emphasis on eliminating implicit bias in the review process. We believe that implicit bias can be reduced through a diverse disciplinary review committee and having implicit bias awareness training. These two measures together can ultimately address the concern of the role bias plays in the disciplinary review process.[9–14]

RECOMMENDATIONS

Your AMA-MSS Committee on Medical Education recommends the following:

1) That the AMA-MSS adopt the first Resolved clause of Resolution 17 (I-17) as amended by insertion and deletion as follows:

> RESOLVED, That our AMA ~~advocate~~ work with appropriate stakeholders, such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), to support: (1) increased diversity and implementation of implicit bias training to faculty responsible for assessing medical students' performance, including the evaluation of professionalism; (2) increased diversity and implementation of implicit bias training in any group of faculty (counsel, panel, board, etc.) responsible for investigating and ruling upon disciplinary matters involving medical students, and that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring.

2) That the AMA-MSS not adopt the second Resolved clause of Resolution 93 (I-17).

3) That the remainder of this report be filed.

ACKNOWLEDGEMENTS

This report was assembled by members of the 2019-20 AMA-MSS Committee on Medical Education (James Docherty, Kirtan Patel, Brendan Schmidt).

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report B
(I-19)

Introduced by: MSS Committee on Medical Education

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 2018 MSS Annual Meeting, Resolution 33 asked the AMA to support changes to Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accreditation standards to meet those of the Americans with Disabilities Act Amendments Act of 2008 and for the AMA to adopt technical standards as recommended in a publication by the American Association of Medical Colleges (AAMC). The AMA-MSS Assembly supported the spirit of the resolution but noted the concerns of the A-18 Reference Committee and referred the resolution for study to the Committee on Medical Education (CME). The resulting report at A-19 asked the AMA to urge stakeholders to create a more transparent and accessible process for applying for accommodations. The AMA-MSS Assembly again supported the spirit of the report but noted the concerns (about the lack actionable recommendations from the report) of the A-19 Reference Committee and re-referred the report for study. Your CME researched current policy with regards to accessibility. This report begins with an overview of these policies and institutional actions towards students with disabilities. It then examines the resolved clauses of Resolution 33-A-18, and discusses feasibility, scope, impact and unintended consequences of the resolution.

BACKGROUND

Current Policy

Our AMA and MSS both have extensive policy in regard to diversity and support among medical students and medical staff in regard to disability, as is well laid out in the original resolution. Enhancing diversity, equal access, creating an effective learning environment, enhancing accommodations, support groups, and stigmatization are some of the issues on which the AMA and MSS hold current policy. While AMA has policy to work with LCME on many issues, no comprehensive standards regarding the American Disabilities Act (ADA) and technical standards for disabilities were outlined in AMA policy. Notably, recently passed at A-19, D-295.929 asks our AMA to work with stakeholders to study barriers to medical trainees and revise technical standards as needed.

Issues regarding institutional approaches to disability accommodations

The adoption and implementation of technical standards that are in compliance with the 2008 revision of the ADA varies widely between individual institutions. Current literature describes several ways in which this may be problematic for the admission and training of otherwise qualified medical students.

Notably, many institutions currently adopt what may be defined as “organic” rather than “technical” functional standards. Organic functional standards largely highlight a student’s limitations or deficits rather than their abilities, such as requiring them to perform a specific task without some form of assistance.[1,2] Additional studies find that most US medical schools adopt technical standards that do not explicitly support the use of accommodations to accomplish required medical activities.[3] Rather, technical functional standards highlight a student’s ability to perform a task with or without assistance, largely focusing on the “what” rather than the “how.” The presumed argument for organic functional standards involves concerns about patient safety, cost and board exam performance. Still, there is minimal empiric evidence suggesting that medical professionals with disabilities pose a threat to patient safety. The ADA prohibits cost from being used as a pre-requisite for discrimination and also requires appropriate accommodations to be made for licensure testing as well.[1] Proponents argue that technical functional standards allow for medical education to remain up to date with the vast array of assistance technology that is becoming available to medical students with disabilities.

Another major concern involves the availability of access to an institution’s technical standards and other resources for disability accommodations. One study found that nearly one in five schools did not publish their technical standards online. For those that did publish their technical standards online, 31% were deemed “very difficult” to access.[3] Other issues with accessibility include unclear instructions about requesting accommodations and which party holds primary responsibility for initiating these services as well as inconsistent support across an individual campus for completing these requests.[3,4] Finally, many students with disabilities may still be discouraged by underlying implicit biases regarding their disability.[5]

Efforts taken by institutions to improve accommodation access

Though virtually no data exists that systematically describes the internal review of disability access by institutions, several schools have taken steps towards improving access to disability accommodations, many occurring following the widely read 2018 AAMC report on disability accommodations.[4]

In 2018, the University of Michigan Medical School reconfigured its own technical standards to focus on students’ required functions and to highlight the interactive and individualized process the school uses to determine whether and how it can accommodate students with disabilities.[6] The University of Minnesota has developed what is referred to as the “college model”, through which administration would continuously evaluate and address the needs and appropriate accommodations for all health professional trainees.[7] In addition, the university’s accommodation-friendly technical standards are clearly outlined online alongside contact sources for students with questions about their own functional limitations.[8] Finally, the University of California at San Francisco School of Medicine, in partnership with many other institutions across the country, has developed the “UCSF Faculty Training Series”, an eight part online video training series to guide faculty who work with students with disabilities.[9]

Summary of recommendations & areas where future understanding is needed

Overall, the literature studies on the accessibility of disability accommodations most consistently suggested the following recommendations:

- Critically review, devise and continue to update technical standards in order to focus on the ability to achieve key competencies rather than on how students achieve them.[1,2,4]
- Include disability in statements or other efforts towards welcoming diverse applicants to the school.[2,4,5]
- Make clear and accessible the technical standards and procedures for requesting accommodations.[1,2,4]

- Ensure that the process of making decisions about accommodations involves ongoing interaction between the student with a disability and an individual with expertise in disability accommodations and ADA requirements who is separate from academic evaluation of the student.[2]
- Promote awareness and open discussion of implicit and explicit biases regarding students and physicians with disabilities and, where appropriate, advocate for the advantages of physicians with disabilities.[5]

Overall, the literature studies on the accessibility of disability accommodations most consistently noted the following as current gaps in understanding and need for future research:

- A better understanding of the accommodation needs of medical students and physicians with disabilities, as well as evidence-based approaches for addressing those needs.[10]
- Understanding of the actual experiences of medical students who matriculate and request accommodations.[10]
- Understanding of reasons for medical schools' reluctance to accommodate to the guidelines set forth by the ADA.[10]

DISCUSSION

Scope and Purview of the AMA

Support of colleagues and study of barriers is within the scope of the AMA and AMA-MSS. However, the actions proposed in the resolution are not within the AMA's purview as it is not an accrediting body and as such does not have the authority to enforce or enact the technical standards. Furthermore, it is not within the purview of the AMA-MSS to enact policies that define essential skills and abilities expected of medical students considering that the organization is student-run.

Impact

As standards from ADA are already required to be implemented at any public or private institution which receive federal funding, as well as other regulations enforced by federal and state laws, there is not sufficient reason to adopt additional standards. Doing so would also create repetition of current AMA and AMA-MSS policies.

Unintended Consequences

One of the most significant unintended consequences that would arise from adopting the resolution with its original language is that it would tie AMA-MSS policy to that of other organizations. In turn, this could strain relations between our MSS and the involved organizations such as the LCME and COCA. These organizations along with the AAMC already have established policies that require schools to accommodate enrolled disabled students and to publish technical standards that are in compliance with the ADA. By asking these organizations to act on an issue that they have already addressed, the resolution undermines their efforts with its original language.

Additionally, the resolved clauses run the risk of becoming outdated with their original wording given that they cite specific policies (e.g. the ADA of 2008) that would potentially nullify them if amended or replaced with new legislation.

CONCLUSION

Medical student access to accomodations is often times difficult. Many schools adopt more organic technical standards without expanding these standards to consider how students with differential needs

can accomplish a task, thus researching improvements to technical standards would benefit students. One out of five schools do not publish their technical standards online and those that do often contain minimal language about how to access/appeal accommodations, putting the onus on students navigate acquiring the accommodations rather easy access. Thus, recommending medical schools more explicitly state how to acquire accommodations to ease access with better researched technical standards would overall benefits those students who are differently abled.

RECOMMENDATIONS

Your AMA-MSS Committee on Medical Education recommends that the following recommendations be adopted in lieu of MSS Resolution 33-A-18, and the remainder of this report be filed:

1. That our AMA amend D-295.929 by addition as follows:

    1) That our American Medical Association work with relevant stakeholders to study available data on medical trainees and students with disabilities and consider revision of technical standards for medical education programs; and be it further

    2) That our AMA work with relevant stakeholders to study available data on medical graduates and students with disabilities and challenges to employment after training and medical education.

    3) That our AMA work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms.

2. That our AMA amend D-90.991 by addition and deletion as follows:

    1) Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians and medical students with disabilities including but not limited to: (a) enhancing representation of physicians and medical students with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians and medical students with disabilities in the AMA

    2) Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians and medical students with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.

    3) Our AMA supports physicians**,** ~~and~~ physicians-in-training**,** and medical student education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

ACKNOWLEDGMENTS

This report was assembled by the 2019-20 AMA-MSS Committee on Medical Education (James Docherty, Joseph Camarano, Andrew Ford, Jay Patel)

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LGBTQ+ ISSUES AND MINORITY ISSUES COMMITTEE

MSS LGBTQ+ and MIC Report A
(I-19)

Introduced by: MSS Committee on LGBTQ+ Issues, MSS Minorities Issues Committee

Subject: Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 2017 Interim meeting, the AMA-MSS referred MSS Resolution 30- "Recognizing LGBT Individuals as Underrepresented in Medicine" to study. The following "Resolved" clauses are found in the original resolution:

> RESOLVED, That our AMA advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident and provider diversity; and be it further
>
> RESOLVED, That our AMA issue a statement of support to expand the definition of "underrepresented in medicine" to include LGBT individuals.

The resolution was referred to study due to a broad range of possible implications. The MSS Committee on LGBTQ+ Issues and the MSS Minority Issues Committee have identified the following points that adequately satisfy the purpose of referral:

(1) To clarify all potential consequences (both positive and negative) of the inclusion of the LGBTQ+ community as "underrepresented in medicine"
(2) To recommend solutions to noted consequences of considering the LGBTQ+ community as "underrepresented in medicine"
(3) To recommend alternative solutions to the LGBTQ+ community's underrepresentation in medicine separate from the formal addition of LGBTQ+ into the definition of "underrepresented in medicine."

The Joint Report was initially submitted to the MSS at the 2018 Interim meeting. The report was re-referred for further study due to variations in statistics that were presented and to further explore the spirit of the report.

BACKGROUND

Underrepresented in Medicine Definition

The Association of American Medical Colleges (AAMC) established its Office of Minority Affairs in 1969 in response to the civil rights movements in the 1950s and 1960s. With the help of the federal Office of Economic Opportunity, novel policies were created by the AAMC that identified an ethnic or racial group as “underrepresented” if its physician proportion was less than its general proportion in the population; these policies established a goal to advocate for population parity [1]. In 2003, the AAMC established a definition for Underrepresented in Medicine (URM) as follows: racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population. The goals of this change were three-fold:

- To shift focus from a fixed aggregation of four racial and ethnic groups to a continually evolving underlying reality.
- To shift focus from a national perspective to a regional or local perspective on underrepresentation, and
- To stimulate data collection and reporting on the broad range of racial and ethnic self-descriptions [2].

Definition of Sexual and Gender Identities

Sex is defined as the biological characteristics of males and females and gender as a cultural indicator of a person’s personal and social identity (ie, masculinity or femininity). Sexual orientation refers to a person's sense of identity based on enduring attractions, related behaviors, and membership in a community of others who share those attractions. Gender identity is a person’s internal experience of their own gender, how they express themselves to others, as well as their socially assigned gender. Individuals can belong to the LGBT community by virtue of their sexual orientation, gender identity, or both of these identity aspects. Individuals that belong to the LGBT community with respect to their sexual orientation self-identify as something other than straight/heterosexual. Those that belong to the LGBT community with respect to their gender identity self-identify as not having the same gender identity as the sex assigned at birth (also called natal sex) [3-8].

The acronym LGBTQ+ is an umbrella term encompassing people who identify their sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as transgender; the last two components of the acronym can stand for queer or questioning and are meant to encompass all identities that are not heterosexual or cisgender. While these subpopulations can be viewed as discrete categories with different needs, sexual orientation and gender identity also exist along continuums that have the potential to change over time. Although the original resolution only used the acronym LGBT, we felt the intent was to include all sexual and gender minorities.

DISCUSSION

Potential consequences of inclusion of the LGBTQ+ community as underrepresented in medicine (URM)

Positive consequences

The change in the definition of URM to include LGBTQ+ individuals might match the trend that individual institutions have taken regarding diversity and inclusion. Although slightly misrepresented by the verbiage of the resolution, 41.4% of US academic health centers with diversity programs or leaders in 2010 already consider LGBTQ+ individuals as target populations for diversity programs. However, only in 29.5% of the responding institutions did URM classification consider factors other than race and ethnicity, such as socioeconomic status (SES), sexual orientation, and disability [9]. Furthermore, an expansion of the definition could set a precedent to further recognize other underrepresented groups, such as individuals with disabilities, individuals from rural areas, and those with lower socioeconomic statuses.

In addition, working to increase the LGBTQ+ workforce in medicine could be beneficial to patient care, given that LGBTQ+ individuals have been recognized as a health disparities population by the National Institutes of Health (NIH) [10]. Several studies indicate patient-provider concordance has several beneficial consequences, including improved provider empathy, improved patient outcomes, and greater patient satisfaction and adherence [11,12]. Specifically, LGBTQ+ individuals face unique health disparities, including poorer access to health care services, shorter life expectancy, and increased discrimination by health care providers [8, 13-16]. Further, compositional diversity is related to diversity of interaction, and both of these may improve self-reported cultural competency [17]. These studies exemplify how representation of LGBTQ+ individuals in the medical field could help address health care reform for sexual and gender minorities, improve the cultural competency of health care providers, and minimize the negative patient care experiences of LGBTQ+ persons. Furthermore, the ways in which institutions utilize the definition of URM reaches beyond student recruitment to areas such as guiding diversity activities, funded mentoring opportunities, salary support, and internal grants [9].

Negative consequences

The most concerning theoretical consequence of including LGBTQ+ individuals in the definition of URM is the exclusion of groups that have been traditionally considered underrepresented in medicine. The consideration of this potential consequence is particularly important considering that, despite giving the URM designation to marginalized populations based on race and ethnicity, the matriculation of students from URM backgrounds has not significantly improved recently (eg, only 6.7% of 2019 graduated student respondents to medical student exit surveys self-identified as black or African American [18], compared to being more than 13% of the total US population [19]).

Furthermore, we were unable to identify any studies which show that expanding the definition of URM would have any effect on the recruitment and retention of minority applicants. In fact, neither the 2003 change in the AAMC’s definition of

URM nor the LCME creation of a diversity accreditation guideline in 2009 has been associated with decreased underrepresentation of racial and ethnic minorities considered URM; rather, US medical school matriculants have an increased underrepresentation because these racial and ethnic minorities continue to comprise a larger proportion of the US population [20]. This limitation could stem from the fact that the goal of representation in medicine paralleling the proportion of the population has never been achieved.

In addition, if URM is to remain a definition based on proportion of medical students/providers relative to the general population, LGBTQ+ individuals may or may not qualify. According to national surveys conducted by the AAMC in 2018, the number of medical students who did not self-identify as “heterosexual or straight” was 6.8%, 8.4%, and 7.7%, per the *All Schools Summary Reports* of the Medical Student Graduation Questionnaire [21], Medical School Year Two Questionnaire [22], and Matriculating Student Questionnaire [23]. Similarly, the reports showed 0.4%, 0.6%, and 0.7% of respondents identified as a different gender identity from the sex assigned at birth, respectively.

While recent nationally representative surveys have varied in estimates of those who identify as LGBTQ+ in the US, it is estimated that about 4.5-12% self-identify as LGBTQ+ [24-27]. Data collected by the Federal Government show similar estimates, with 92.2-93.4% of respondents identifying as straight or heterosexual and 98.42% identifying as cisgender [28, 29]. Among 18- to 37-year-olds, 84-88% identified as straight or heterosexual and 97.8% identified as cisgender [30-32]. These data would suggest that the percentage of medical trainees who identify as gender and sexual minorities remains on par with the national proportion within the general population of the US, but not of their age-matched counterparts.

It is also important to acknowledge a few possible limitations. First, the diversity of sexual orientation and gender identity experiences are difficult to capture and/or quantify. These data are self-reported, meaning survey respondents may fear the consequences of disclosing their LGBTQ+ status. As a result, surveys may be biased as different LGBTQ+ individuals may be more or less willing to disclose their status [33-36]. Thus, current surveys may be limited in their ability to capture whether respondents claim a sexual or gender minority identity publicly and/or privately. Second, the overall response rate for the Medical Student Graduation Questionnaire was 83% of all US medical school graduates in the Class of 2018, for the Medical School Year Two Questionnaire was 64.3% of active second-year US medical students in the 2018-2019 academic year, and for the Matriculating Student Questionnaire was 71.4% of matriculants to an LCME-accredited medical school that enrolled students in 2018. Data from all three of the AAMC’s 2018 *All Schools Summary Reports* are not generalizable as detailed in the methodology section of the respective reports: “Survey data for participating individuals may not be comparable to data for nonparticipants.” Additionally, the response rates to the sexual orientation question on the 2018

questionnaires was 93.4%, 90.2%, and 92.3%, respectively. The response rates to the gender identity question on the 2018 questionnaires was 94.3%, 91.3%, and 93.4%, respectively. These AAMC surveys may not capture the sexual orientation and gender identity of medical students that do not identify with the labels presented on the surveys. Finally, finding the numbers of LGBTQ+ individuals in the general population is also potentially limited because sexual orientation and gender identity (SO/GI) are not collected uniformly [37,38].

There are no publicly available data available to estimate how many residents or currently practicing physicians identify as LGBTQ+. One paper noted that in a small survey at UCLA, 4% of David Geffen School of Medicine faculty identified as lesbian, gay, bisexual, or transgender [39]. Currently, ERAS does not ask residency applicants for sexual orientation or gender identity. Some of the Faculty StandPoint surveys ask sexual orientation depending on the institution, but none ask about gender identity. AMCAS allows a medical student applicant to add their current gender identity and personal pronouns; however, sexual orientation is not asked. None of the other data collections at the AAMC include SO/GI.

Additionally, expanding the definition of URM to include LGBTQ+ individuals in order to achieve “population parity” is impossible to achieve [40] and could be seen as unconstitutional because of the parallel to “racial balancing” [41].

Finally, although diversifying the health care workforce is commonly identified as a key to facilitate access to quality health care for all and adds value to the community, there is not strong enough evidence to support the claim that more LGBTQ+ physicians would reduce the health disparities that sexual and gender minorities face [42-44].

Solutions to noted consequences

While LGBTQ+ individuals may not be underrepresented in medical school by sheer number, disaggregating the data to better ascertain the nuances and intersectionality of LGBTQ+ identities would provide more information prior to consideration for formal recognition. This would be beneficial because, even within the LGBTQ+ community, disparities affect certain groups disproportionately (eg, transgender patients face more significant barriers than gay and bisexual men) and health disparities are also further propagated by intersectionality with low SES and racial and ethnic minority status.

It may also be appropriate to encourage the AAMC to include questions not only about LGBTQ+ identity in exit surveys, but questions about whether LGBTQ+ individuals feel they can be open about their identity without fear of discrimination at their institutions. As noted in the *Reports on Diversity and Inclusion*, "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine" [45].

Alternatives to formal recognition as "underrepresented in medicine"

As previously stated, LGBTQ+ health disparities and discrimination by healthcare providers are a significant issue in our society, and social identity concordance with a provider as well as physicians having more LGBTQ+ colleagues may help decrease discrimination and alleviate these health disparities. Thus, it can still be possible to encourage medical schools to be more vigilant about LGBTQ+ recruitment into their schools for the stated reasons above regardless of whether sexual and gender identities are incorporated into the definition of a URM. Our AMA should encourage the recruitment and inclusion of sexual and gender minority faculty and the creation of pathways to health care careers and of pipeline programs for sexual and gender minority applicants [46]. Our AMA should further encourage medical schools to adapt their goals to improve representation in medicine based on local population and demands [9].

Beyond recruitment, it is also imperative to encourage medical schools to be intentional and vigilant that their institutions create an environment that allows individuals to openly identify as LGBTQ+ [47]. Someone may be willing to state their sexual orientation and gender identity on a survey, but whether that translates to their willingness to be open about their identities at their institution is unknown [48]. Medical schools should increase their awareness of the potential discrimination that these students may face and have policies to protect these individuals.

CONCLUSIONS

The previous filing of this report at I-18 incorrectly presented some of the data surrounding the number of medical students who identify as "LGBTQ+" and the proportion of the US population that identifies as a sexual or gender minority. However, even with the statistics from the AAMC reports from 2018, the number of medical students who identified as a sexual minority was between 6.8% and 8.4% and those who identified as a gender minority was between 0.4% and 0.7% of all respondents. Based on data collected by the CDC, these rates may be comparable to the national proportions, but not to the proportion of the population similar to medical students in terms of age.

The spirit of Resolution 30 is certainly positive as it attempts to alleviate the health disparities faced by LGBTQ+ patients; but, at this point, there is insufficient evidence to alter the definition of URM, especially given its historical background based on race and ethnicity. Furthermore, the data are poor to understand the representation of sexual and gender minorities in medical students, residents, and providers, let alone in the general population.

A good next step would be moving to disaggregate data of LGBTQ+ individuals in medicine to better understand how many students identify within the different subsets of the LGBTQ+ community and how their LGBTQ+ identities intersect with other identities (eg, racial/ethnic minority, low SES, etc.)

Lastly, regardless of URM classification, we encourage medical schools to be cognizant of the discrimination that LGBTQ+ students and patients face in the health care system and therefore encourage schools to take steps to be inclusive environments for LGBTQ+ students so that they may be open about their identity. As articulated by the AAMC Executive Council after the adoption of URM, medical schools ought to aspire "to achieve the educational benefits of a diverse student body, including enhancing the cultural competency of all the physicians it educates and improving access to care for underserved populations" [41].

RECOMMENDATIONS

Your Committee on LGBTQ+ Affairs and Minority Issues Committee recommend the following be adopted in lieu of Resolution-30-I-17, and the remainder of this report be filed:

RESOLVED, That our AMA advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident and provider diversity; and be it further

~~RESOLVED, That our AMA issue a statement of support to expand the definition of "underrepresented in medicine" to include LGBT individuals.~~

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured; and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.

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Previous

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(I-19)

Introduced by: Taylor Lucas, Chair

Subject: Policy Sunset Report for AMA-MSS Policies

Referred to: MSS Reference Committee
(Pauline Huynh, Chair)

INTRODUCTION

At the 1995 National Medical Student Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-95 and MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including:

- To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
- To assist in the identification of areas where additional policy is needed;
- To help identify and remove outmoded, duplicative, or inconsistent policies;
- To promote efficiency in Assembly deliberations; and
- To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044:

> (1) Review of policies will be the ultimate responsibility of the GC; (2) policy recommendations will be reported to the 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.

MSS POLICY REVIEW

The MSS GC conducted a review of policies adopted or reaffirmed by the MSS Assembly in 2014. Due to past lapses in review, policies from previous years that were not reviewed per the outlined sunset mechanism are also included in this report. Appendix 1 of this report contains a listing of the 178 total policies adopted or reaffirmed in 2014 (or prior years), the recommendation for retention or rescission, and a brief supporting rationale for that recommendation. Many of these policies call for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy. The remaining policies contain general statements of policy that are still relevant, at least in part, and can be referenced by organizations or individuals seeking support for a particular issue. Of the 178 presented for consideration in this

report, 175 of them will be either fully or partially retained as a part of the MSS policy compendium.

REVIEW AND CORRECTION OF MSS POLICY DIGEST

As is appropriate from time-to-time, a full review of the MSS Policy Digest was completed following the 2019 Annual Meeting. During this review, the MSS GC updated policies that had been reaffirmed, removed policies from the digest that have already been sunset, as well as corrected any errors found. The MSS GC also added an index to the MSS Policy Digest to aid readers in finding appropriate policies more quickly. The changes made to the MSS Policy Digest were not novel, they simply corrected errors that were not appropriately implemented when the policies were originally passed, reaffirmed, or rescinded.

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.

APPENDIX 1 – Policy Sunset Report Recommendations for AMA-MSS Policies

Policy #	Title	Policy	Recommendation
10.008MSS	Promoting the Universal Use of Bicycle Helmets	AMA-MSS encourages ~~chapters~~ sections 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.	Retain – still relevant; updated language to "sections"
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~~	Retain – still relevant; Edit to delete last phrase referencing AAP and AAO
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.	Retain – still relevant
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.	Retain – still relevant
20.005MSS	HIV Drug Availability	AMA-MSS will ask the AMA, as set forth in its objective of contributing to the betterment of 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 HIV/AIDS; and (2) encourage the FDA to continue to expedite the evaluation of available drugs used in the treatment of HIV/AIDS	Retain – still relevant; amend title and substitute HIV/AIDS
20.006MSS	HIV~~AIDS~~ Prevention through Educational Programs	AMA-MSS will ask the AMA to support attention to language and cultural appropriateness in HIV education materials and encourage the development of additional materials designed to inform minorities of risk behaviors associated with HIV infection.	Retain – still relevant; amend title

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 <u>and Criminalization</u> Based on HIV Seropositivity Our AMA: (1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of the HIV seropositivity; (3) Encourages vigorous enforcement of existing ani-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 <u>(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.</u>	Retain – still relevant, accomplished

30.006MSS	Support of Programs that Discourage Adolescent Alcohol Consumption	AMA-MSS strongly encourages AMA-MSS ~~chapters~~ sections 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.	Retain – still relevant; Edit to amend "chapters" to "sections" for internal and legal consistency
30.009MSS	Sobriety Checkpoints	AMA-MSS will ask the AMA (1) to support the use of sobriety checkpoints to deter driving following alcohol consumption; and (2) to work with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.	Retain – still relevant
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 smear as a screening tool for anal cancer.	Retain – still relevant
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.	Retain – still relevant
60.022MSS	Altering School Days to Alleviate Adolescent Sleep Deprivation	AMA-MSS will ask the AMA to 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.	Retain – still relevant
60.023MSS	Legal Protection and Social Services for Commercially Sexually Exploited Youth	AMA-MSS will ask the AMA to 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	Retain – still relevant

		for commercially sexually exploited youth.	
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 non-discriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or perceived gender" in any non-discrimination 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."	Retain – still relevant
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 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.	Retain – still relevant
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 or (joint) adoption.	Retain – still relevant; amend
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 up 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.	Retain – still relevant
75.007MSS	Promotion of Emergency	AMA-MSS will ask the AMA to: (1) support public health education relating	Retain – still relevant

	Contraception Pills	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.	
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.	Retain – still relevant
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.	Retain – still relevant
75.012MSS	Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception	AMA-MSS will ask the AMA to (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 pre-conception counseling.	Retain – still relevant
90.001MSS	Handicapped Parking Spaces	AMA-MSS will ask the AMA to support efforts to educate the public on the appropriate use of parking spaces for the handicapped.	Retain – still relevant
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.	Retain – still relevant
95.009MSS	Addressing Emerging Trends in Recreational Drug Abuse	AMA-MSS will ask the AMA to (1) support the appropriate agency in providing continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency in disseminating current and accurate	Retain – still relevant

		information regarding emerging trends in recreational substance abuse.	
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.	Retain – still relevant
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.	Retain – still relevant
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; (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.	Retain – still relevant
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	Retain – still relevant

		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.	
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.	Retain – still relevant
120.005MSS	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.	Retain – still relevant
120.011MSS	Personalized Medication Cards	AMA-MSS will ask the AMA to 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.	Retain – still relevant
130.002MSS	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	Retain – still relevant

		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.	
130.004MSS	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.	Retain – still relevant
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.	Retain – still relevant
140.019MSS	Supporting the Establishment of Guidelines Regarding Online Professionalism	AMA-MSS will ask the AMA to (1) initiate discussion 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	Retain – still relevant

		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.	
140.027MSS	Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education	AMA-MSS will ask 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.	Retain – still relevant
140.028MSS	Solitary Confinement	AMA-MSS will ask the AMA to (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.	Retain – still relevant
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 limitation 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	Retain – still relevant

		used in undergraduate medical education.	
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant

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 indication for a techniques of their use.	Retain – still relevant
150.013MSS	Mercury in Food as a 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 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.	Retain – still relevant
150.014MSS	Healthy Food Options in Hospitals	AMA-MSS will ask the AMA to encourage that healthy food options be	Retain – still relevant

		available, at reasonable prices and easily accessible, on hospital premises.	
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 enrollment 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.	Retain – still relevant
150.021MSS	Accurate Reporting of Fats in Nutrition 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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant
150.028MSS	Increasing Health Food Choices	AMA-MSS will ask the AMA to advocate for positive financial incentives to	Retain – still relevant

	Among Families Supported by the Supplemental Nutrition Assistance Program	encourage healthier food purchases for Supplemental Nutrition Assistance Program participants.	
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 licenses and/or certified health mobile produce vendors.	Retain – still relevant
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.	Retain – still relevant
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 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.	Retain – still relevant
155.004MSS	Advocating for Research on Physician-Initiated Conversations about Treatment Cost	AMA-MSS will ask the AMA to (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.	Retain – still relevant

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.	Retain – still relevant
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*.	Retain – still relevant
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 Sport 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.	Retain – still relevant; Edit to remove references to specific professional health organizations
160.016MSS	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.	Retain – still relevant
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.	Retain – still relevant

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.	Retain – still relevant
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.	Retain – still relevant
160.029MSS	Protecting Medical Students' Rights as Patients	AMA-MSS will ask the AMA to 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	Retain – still relevant

		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, and physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from	

		unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board	

		(IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health	

		emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.	
165.003MSS	Advocacy for Rapid and Timely Implementation of the State Children's Health	AMA-MSS will actively promote the rapid and timely enrollment of eligible children in their State Children's Health Insurance Program through its State Medical Student Sections and chapters.	Retain – still relevant

	Insurance Program		
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.	Retain – still relevant
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.	Retain – still relevant
170.014MSS	Recognizing the Importance of the Theory of Evolution in Science Education	AMA-MSS will ask the AMA to endorse the teaching of the theory of evolution as an integral part of science education.	Retain – still relevant
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.	Retain – still relevant
180.004MSS	Sexual Orientation as Health Insurance Criteria	AMA-MSS will ask the AMA to oppose denial of health insurance on the basis of sexual orientation <u>as well as undue barriers to recommended screening or treatment for conditions for which particular sexual orientations may be a risk factor</u>.	Retain – still relevant; amend
180.015MSS	Privacy Issues for Minors Regarding Insurance Company Explanation 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	Retain – still relevant

		discuss it with their physician or share it with their spouse, parent, or guardian.	
180.016MSS	Emergency Department Insurance Linking	AMA-MSS will ask the AMA to support the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing emergency medical services.	Retain – still relevant
200.002MSS	Support of the NHSC Loan Repayment Program	AMA-MSS will ask the AMA to support the continuation and expansion of the NHSC loan repayment program.	Retain – still relevant
200.018MSS	Incorporating Community Health Workers into the U.S. Health Care System	AMA-MSS will ask the AMA to (1) encourage 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) support 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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		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.	
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.	Retain – still relevant
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 and/or AMA Chief Health Equity Officer the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators.	Retain – still relevant; Edit to include new position of AMA Chief Health Equity Officer
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.	Retain – still relevant

250.010MSS	Medical Supply Donations to Foreign Countries	(1) AMA-MSS will ask the AMA to encourage the continuing donation of medical equipment, drugs, computers, textbooks, and any other unused medical supplies. (2) AMA-MSS encourages ~~chapters~~ sections to collect medical supplies from their local physicians, hospitals, clinics, etc.	Retain – still relevant; amend
250.019MSS	Global HIV/AIDS Prevention	AMA-MSS will ask the AMA to (1) support continued funding efforts to address the global HIV~~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.	Retain – still relevant; amend
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.	Rescind clause 1 - Reference a mutable policy from an outside org, Retain clause 2
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.	Retain – still relevant
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.	Retain – still relevant

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 without jeopardizing prescriber-identifiable data.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant

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.	Retain – still relevant
295.007MSS	Curriculum in Child Abuse and Neglect	AMA-MSS will ask the AMA to urge all US medical schools to include in their required curriculums both formal lectures and clinical instruction in the subject of child abuse and neglect.	Retain – still relevant
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.	Retain – still relevant
295.090MSS	Status of Graduates of Puerto Rico LCME Medical Schools	The AMA-MSS recognizes ~~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 believes that students from these programs should be treated as U.S. students.	Rescind; MSS no longer has a liaison position to LCME
295.093MSS	FREIDA Online	AMA-MSS will promote the use of AMA FREIDA Online.	Retain – still relevant
295.098MSS	Distribution of the AMA Code of Medical Ethics	AMA-MSS will ask the AMA to distribute unannotated copies of the Code of Medical Ethics to every first-year medical student.	Retain – still relevant
295.101MSS	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	Retain – still relevant

		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.	
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	Retain – still relevant

		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.	
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		modifications to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam.	
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		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.	
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.	Retain – still relevant
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 Skills Exam and their implications for US medical students.	Retain – still relevant
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.	Retain – still relevant
295.176MSS	Unified Medical Education	AMA-MSS supports a Unified Accreditation System for allopathic and osteopathic graduate medical education programs.	Retain – still relevant
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	Retain – still relevant

		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.	
295.178MSS	Motivational Interviewing in Medical Education	AMA-MSS supports the incorporation of motivational interviewing into medical school curriculum.	Retain – still relevant
295.179MSS	AMA Support for Increasing Access to Shadowing Opportunities for Pre-medical Students	AMA-MSS encourages state medical societies to create a database of physicians willing to provide shadowing opportunities to undergraduate students.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
295.183MSS	Combating Sex-Linked	AMA-MSS will ask the AMA to: (1) urge all medical examination agencies to	Retain – still relevant

	Discrimination of Denying Special Request for Lactation During Medical Board Examination	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.	
295.184MSS	Medical Student Involvement in Handoffs	~~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])~~ 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.	Retain – still relevant; amend
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.	Retain – still relevant
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.	Retain – still relevant
305.062MSS	Industry Support of Professional	AMA-MSS encourages aggressively decreasing reliance on industry support	Retain – still relevant

	Education in Medicine	for medical education and support alternative funding mechanisms to finance quality medical education.	
310.024MSS	Resident Physician Organizations	AMA-MSS supports the formation of independent house staff organizations.	Retain – still relevant
310.031MSS	Resident/Fellow Work and Learning Environment	(1) AMA-MSS will ask the AMA 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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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;	Retain – still relevant

		and (2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program (NRMP) who fail to match.	
315.003MSS	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.	Retain – still relevant
345.007MSS	Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications	AMA-MSS aims to reduce stigmatization of 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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		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 within the setting of a patient-centered medical home.	
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.	Retain – still relevant; Edit to delete 2013
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.	Retain – still relevant
420.008MSS	Advance Directives During Pregnancy	AMA-MSS will ask the 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.	Retain – still relevant

435.004MSS	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.	Retain – still relevant
435.009MSS	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.	Retain – still relevant
435.010MSS	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,	Retain – still relevant

		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.	
440.008MSS	Tuberculosis Resurgence and Physician Awareness	AMA-MSS will ask the AMA to: (1) work with the Centers for Disease Control (CDC) to educate physicians and the public on the recent resurgence and unusual presentations of tuberculosis; and (2) work with the CDC to promote improved methods of screening, treatment, and prevention of further transmission of tuberculosis.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant

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.	Retain – still relevant
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.	Retain – still relevant
440.034MSS	Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning	AMA-MSS will ask the AMA to support skill-appropriate medical student involvement in pandemic disaster medicine and public health preparedness planning and response.	Retain – still relevant
440.035MSS	Increasing Advocacy for and Public Awareness of the Lack of 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.	Retain – still relevant
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.	Retain – still relevant
440.043MSS	Promoting Celiac Disease Screening and Usage 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	Retain – still relevant

		and high-risk population definitions for general and pediatric populations by appropriate stakeholders.	
440.044MSS	Sunscreen and Sun Protection Counseling by Physicians	AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sun-protective behavior.	Retain – still relevant
440.045MSS	Development of a Standardized Post-Conducted Electrical Device Exposure Medical Protocol and Education 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.	Retain – still relevant
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.	Retain – still relevant
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.	Rescind; Overshadowed by 440.053MSS
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.	Retain – still relevant
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	Retain – still relevant

		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.	
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.	Retain – still relevant
450.001MSS	AMA Endorsement of the WHO Surgical Safety Checklist	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.	Retain – still relevant
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	Retain – still relevant

		technology for uses other than human reproduction by supporting basic science research programs that pursue medically therapeutic procedures such as organ or tissue transplantation.	
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.	Retain – still relevant
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.	Retain – still relevant
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;	Retain – still relevant

		(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.	
460.105	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.	Retain – still relevant
470.003MSS	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.	Retain – still relevant
470.007MSS	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.	Retain – still relevant
480.013MSS	The Role of Medical Students in the Development of	AMA-MSS will work with our AMA and other relevant organizations to (a) facilitate active and timely medical student input on Health Information	Retain – still relevant

	Health Information Technology	Technology research and development; and (b) continually determine how best our AMA-MSS can assist in the improvement of Health Information Technology.	
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.	Retain – still relevant
480.019MSS	Best Practices for Mobile Medical Applications	AMA-MSS will ask the AMA to develop and publicly disseminate a list of best practices guiding the development of mobile medical applications.	Retain – still relevant
490.018MSS	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.	Retain – still relevant
490.019MSS	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.	Retain – still relevant
490.020MSS	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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		their children in various settings ranging from schools to clinics.	
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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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	Retain – still relevant

		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.	
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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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.	Retain – still relevant
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	Rescind clauses 4, 6, 9; Retain all others

		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 deadlines. ~~(9) That the MSS Internal Operating Procedures be revised to require that all resolutions~~	

		~~recommended for reaffirmation by the MSS Reference Committee will require 1/3 of all present delegates to vote for its extraction from the Final Reference Committee report.~~	
645.032MSS	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.	Retain – still relevant
655.022MSS	MD/PhD AMA Membership	AMA-MSS will develop a mechanism for MD/PhD students and other students require 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.	Retain – still relevant
660.001MSS	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.	Retain – still relevant
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.	Rescind – Accomplished

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Reference Committee Report

The Medical Student Section again utilized a completely Virtual Reference Committee (VRC) for the 2019 Interim Meeting. The VRC allows students to access, review, and provide testimony on the resolutions and reports in advance of the Interim Meeting and in lieu of a standard in-person Reference Committee Hearing.

These comments were reviewed by the Reference Committee to create the final Reference Committee Report, which will be made available on Thursday, November 7th, one week in advance of the MSS Assembly Meeting. The final report and its recommendations will serve as the basis for extraction, discussion and voting at the onsite Assembly Meeting.

Visit the MSS meeting webpage to download the Reference Committee report, when it becomes available: https://www.ama-assn.org/member-groups-sections/medical-students/mss-interim-meeting-agenda-resources

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Education Materials

Schedule of education sessions

Friday, November 15, 2019

8:00-8:45am	Managing Gender Bias in Medical Careers
8:30-9:15am	Adverse Childhood Experiences and Trauma Informed Care for Migrant Populations and Displaced Peoples
9:00-9:45am	Case Demonstrations Regarding Women's Health Care with Limited Resources
1:00-1:45pm	Professionalism on Social Media, and Its Uses in Networking, Advocacy, and Professional Development
1:30-2:15pm	I am Human: A Look at Shortcomings in the United States Prison Health Care System
2:00-3:00pm	Seeking Mental Health Care as Physicians and Future Physicians
2:30-3:15pm	Structural Violence - Understanding the Bias Against Patients with a History of Substance Abuse
3:00-3:45pm	Cultural Humility & Implicit Bias: Moving Toward Equitable Health Care
3:30-4:15pm	Unraveling the Mysteries of Surprise Billing

Saturday, November 16, 2019

8:00-8:45am	U.S. Health Care Reform- Diving into the Economic, Physician and Patient Aspects of Proposed Health Care Plans
8:30-9:15am	Developing Sustainable Global Health Projects in the Age of Voluntourism
9:00-9:45am	Identifying Clinical Problems and Driving Needs-Oriented Innovation in Medicine
9:30-10:15am	Using Cost-effectiveness to Determine Coverage Priorities

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10:00-10:45am Telemedicine and Mobile Apps - Accessing Birth Control Without Stepping Foot in a Clinic
Speaker biographies

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Managing Gender Bias in Medical Careers

2019 AMA Interim Meeting

8 a.m. – 8:45 a.m. | Friday, November 15 | La Costa Marriott Marquis | San Diego, California

Program Description

Gender bias occurs at all stages of medical training and practice and can interfere with one's ability to provide expert care. This program aims to educate participants about bias in the medical field, and especially bring to attention forms of bias that may not be apparent at first thought.

This live activity at the 2019 Interim meeting will begin with a lecture to define gender bias followed by a breakout session where learners can identify and correct gender bias in a medical setting. This activity will provide tactics of how to manage gender bias.

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Adverse Childhood Experiences and Trauma Informed Care for Migrant Populations and Displaced Peoples

2019 AMA Interim Meeting

8:30 a.m. – 9:15 a.m. | Friday, November 15 | Coronado Marriott Marquis | San Diego, California

Program Description

Violence, famine, and natural disasters can lead to necessary or forced migrations. The ordeals associated with fleeing one country in pursuit of safety in another are traumatic. Upon arrival to a new country, migrants face additional traumas while navigating social support services and experiencing discrimination and frequent relocation. These traumas are especially damaging to children and can have lifelong effects. Appropriate trauma-informed care (TIC) can potentially prevent or ameliorate long-term consequences of trauma.

With increasing numbers of migrants arriving and living in the United States, physicians need to be versed in how to screen for trauma and adverse childhood experiences (ACEs) and provide appropriate TIC for children and adults. This live activity explores how to identify past trauma related to migration and provide TIC to displaced peoples and migrant populations.

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Case Demonstrations Regarding Women's Health Care with Limited Resources

2019 AMA Interim Meeting

9 a.m. – 9:45 a.m. | Friday, November 15 | La Costa Marriott Marquis | San Diego, California

Program Description

In collaboration with MSS members of the Women in Medicine Committee, case demonstrations will explore women's health care in three different settings: natural disasters, rural areas, and at the US-Mexico border. These settings will demonstrate the challenges associated with providing health care for female patients with limited resources.

In this live activity at the 2019 Interim Meeting, learners will be challenged to creatively develop care plans for female patients who might be undocumented, lived through a traumatic natural disaster or travel large distances to receive care. After each session, there will be a debrief with the physician that will help audience members understand the best way to utilize limited resources to take care of their patients.

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Professionalism on Social Media and Its Uses in Networking, Advocacy, and Professional Development

2019 AMA Interim Meeting

1 p.m. – 1:45 p.m. | Friday, November 15 | La Costa Marriott Marquis | San Diego, California |

Program Description

Social media is widely used by many to achieve both personal and professional goals. As more social media platforms emerge, the task of understanding their uses becomes increasingly complex. With an increasingly digital world, physicians must be prepared to take on the responsibilities that come with maintaining social media accounts.

In this live activity at Interim 2019, learners will review principles of professionalism, ethics, and confidentiality. This will include discussing the differences in audiences, types of communication strategies, and certain topics that might be best suited for each platform. The speaker will explain how to use these platforms to network with other professionals, promote one's own work and accomplishments, provide health education to their followers, and advocate for health policy.

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I am Human: A Look at Shortcomings in the United States Prison Health Care System

2019 AMA Interim Meeting

1:30 p.m.– 2:15 p.m. | Friday, November 15 | Coronado Marriott Marquis | San Diego, California | .75 AMA PRA Category 1 Credits

Program Description

Burdened with one of the largest prison populations in the world, the U.S. prison system struggles to provide sufficient physical and mental health services, nutrition, and mental support to individuals who are incarcerated. This burden is exacerbated as prison, at times, is the first venue individuals are able to receive consistent care. Although federal spending in prisons has risen in recent decades, there remains a particular need for mental health services. This live activity at the 2019 Interim meeting will explore the physical, mental, and social impacts of inadequate health care for incarcerated people. To illustrate this impact, a case study will explore the health care experience of an incarcerated individual both during their sentence and once their sentence is served.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of *.75 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Seeking Mental Health Care as Physicians and Future Physicians

2019 AMA Interim Meeting

2 p.m. – 3 p.m. | Friday, November 15 | Marina D
Marriott Marquis | San Diego, California

Program Description

Pursuing mental health care as a medical professional is often stigmatized and can lead an individual to forego care in fear of jeopardizing his or her career or status. Furthermore, some physicians may be required to report their mental diagnosis or treatments to the state licensing board.

This live activity at Interim 2019 will discuss current policies related to physician mental health. Reporting requirements, employment or residency application scrutiny, and other consequences of seeking psychiatric or psychological care will be discussed. Several resources will be named to aid physicians and future physicians to safely seekmental health care, while safeguarding the well-being of their patients. A panel of speakers, who are experts at guiding physicians who seek mental health care, will support this dialogue.

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Structural Violence –

Understanding the Bias Against Patients with a History of Substance Abuse

2019 AMA Interim Meeting

2:30 p.m. – 3:15 p.m. | Friday, November 15 | Coronado Marriott Marquis | San Diego, California

Program Description

With sponsorship by the MSS Committee on Long Range Planning, this live activity at the 2019 Interim meeting will examine the impact of structural (institutional) violence related to drug offenses on health care outcomes. Using marijuana legalization as a case study, this didactic session will conclude with a conversation on the impact of drug legalization on health care decision making.

The program will begin with an introduction highlighting: key statistics on structural violence, the history of substance use stigma, and the legal milieu of illicit substances. Guided by a moderator, legal cases involving marijuana use will allow group learning through dissection around the legal and medical implications of the case. Learners will have an opportunity to discuss what new and long-term considerations will arise in the field of health care, if marijuana is legalized nationally.

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Cultural Humility & Implicit Bias: Moving Toward Equitable Health Care

2019 AMA Interim Meeting

3 p.m. – 3:45 p.m. | Friday, November 15 | La Costa Marriott Marquis | San Diego, California | .75 AMA PRA Category 1 Credits

Program Description

Implicit biases are subconscious associations that can lead to a negative evaluation of a person based on characteristics such as race or gender. Implicit bias may affect how providers and other clinicians interact with patients in terms of communication, treatment protocols or recommended treatment options leading to health care disparities. To achieve health equity, health care providers have a responsibility to recognize and mitigate the effect of implicit bias in all interactions with patients.

This live activity at Interim 2019 will define and demonstrate implicit bias and cultural humility. We will then go into a breakout session that helps participants identify common biases. In the debriefing, we will discuss ways clinicians can combat implicit bias in daily practice and utilize self-reflection to build cultural humility.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

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AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Unraveling the Mysteries of Surprise Billing

2019 AMA Interim Meeting

3:30 p.m. – 4:15 p.m. | Friday, November 15 | Coronado Marriott Marquis | San Diego, California

Program Description

Surprise billing, or unanticipated out-of-network billing, occurs when an individual is billed the difference for receiving a service which unexpectedly turns out to be outside of their insurer's network. For example, a patient treated by an emergency department that is out of network may receive unexpected bills, furthering their medical expense burden.

This live activity at the 2019 Interim meeting will clarify common myths of surprise billing and address current policy and legislation at the state and federal level. A case-based Q&A session will allow learners to work through current examples of surprise billing. Addressing the nuances of this topic will allow health care providers to speak to patients in an informed way and advocate for solutions to surprise billing.

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U.S. Health Care Reform-

Diving into the Economic, Physician and Patient Aspects of Proposed Health Care Plans

2019 AMA Interim Meeting

8 a.m. – 8:45 a.m. | Saturday, November 16 | La Costa Marriott Marquis | San Diego, California

Program Description

Ever since the enactment of the Affordable Care Act (ACA) and Medicaid expansion in the United States, there has been robust discussion of continued health care reform. Despite these changes, the Census Bureau claims 27.5 million Americans were uninsured in 2018. While there is consensus that health care reform is needed, the question of what this reform should look like remains.

This live activity at 2019 Interim will inform learners about the current and proposed reform to the U.S. health care system, guided by a panel of experts. The panel will explore the economic aspects as well as the impact to physicians and patients. The general plans to be discussed include the American Health Care Act of 2017, ACA improvements, Medicare Buy-in and Medicare for All.

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Developing Sustainable Global Health Projects in the Age of Voluntourism

2019 AMA Interim Meeting

8:30 a.m. – 9:15 a.m. | Saturday, November 16 | Coronado Marriott Marquis | San Diego, California

Program Description

Each year, volunteering on global health service trips increases in popularity for physicians, medical students, and pre-medical students. There is an undeniable appeal to travel somewhere new and exotic to care for patients who otherwise may not have consistent access to modern medical care. However, the moral and ethical consideration of delivering or "practicing" care on underprivileged populations raises concerns of providing care with cultural competency. There are geopolitical consequences when volunteer service is blurred with tourism.

In this live activity, learners will be able to offer a thoughtful critique of voluntourism and evaluate the benefits and costs of international service trips. Students and physicians will learn how to create opportunities for global health service that are meaningful, sustainable, and ethical.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Identifying Clinical Problems and Driving Needs-Oriented Innovation in Medicine

2019 AMA Interim Meeting

9 a.m. – 9:45 a.m. | Saturday, November 16 |La Costa Marriott Marquis | San Diego, California

Program Description

The synergy of health care innovation and medicine is an emerging field which can provide solutions for the needs of physicians and patients. The Clinical Problem Database (CPD) was created by the AMA and Sling Health, a nonprofit health incubator, to provide a forum for AMA members to drive needs-oriented innovation.

In this live activity at Interim 2019, a didactic session will review a collection of clinical problems sourced from the CPD. With guidance from Sling Health representatives, learners will develop "needs statements" using clinical examples to develop entrepreneurial skills and explore solutions for problems in clinical care and health care delivery

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Using Cost-effectiveness to Determine Coverage Priorities

2019 AMA Interim Meeting

9:30 a.m. – 10:15 a.m. | Saturday, November 16 |Coronado Marriott Marquis | San Diego, California

Program Description

Rising health care costs in the United States have led to increased interest in the use of cost-effectiveness as a criterion for determining coverage priorities. With increased discussion of a "Medicare for All" single-payer system, unanswered questions remain about how to constrain health care costs.

In this live activity at Interim 2019, attendees will learn the fundamentals of cost effectiveness analysis, the process of determining coverage priorities, and the ethics of factoring cost into health care decision making. Learners will be able to articulate how health care systems utilize quality and cost in prioritizing treatments and challenges inherent in these approaches. Group discussions will provide an opportunity to apply knowledge and play the role of policy makers determining how best to allocate limited resources.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Telemedicine and Mobile Apps - Accessing Birth Control Without Stepping Foot in a Clinic

2019 AMA Interim Meeting

10 a.m. – 10:45 a.m. | Saturday, November 16 | La Costa Marriott Marquis | San Diego, California

Program Description

Medical education teaches the importance of access to birth control methods for men and women, but there is not accurate information in the medical curriculum about new methods for achieving birth control prescriptions outside of the clinic. Telemedicine is a growing industry to fill this need of online-based access to birth control, especially for patients living in medically underserved areas.

In this live activity at Interim 2019, learners will play an interactive game of Q&A about the eligibility and patient use of mail-order birth control. Moderators will provide a brief history of telemedicine and provide tools of how health care providers should address prescriptions patients may receive outside of clinic-based care. Participants are requested to bring a phone or laptop to the activity.

Speaker biographies

Lukmanafis Babajide, MD



Dr. Babajide is a third-year psychiatry resident at Rutgers New Jersey Medical School and is interested in working with marginalized populations. He went to UT Southwestern Medical School in Dallas and Davidson College for undergraduate studies. He majored in Sociology in undergrad and this has allowed to him to use a sociological lens in practicing medicine so far. He plans to further his education in both medicine and sociology in the future.

Caitlin Boylan



Caitlin Boylan has been working in the social media industry since 2011, getting her start in digital marketing for the Chicago area arts and restaurant industry. She has been working at the AMA since 2014 in the social media department, and co-launching the AMA Ambassador Program in 2017. She is a graduate of Illinois State University.

William R Brown, Jr., MD, MPH, FAAP



Dr. Brown received his medical degree from Kansas University Medical Center and his MPH from Johns Hopkins. He currently volunteers as an Assistant Clinical Professor in the Department of Pediatrics at John A. Burns School of Medicine in Honolulu, HI. When Dr. Brown is not in the clinic, he enjoys reading many books with his grandchildren.

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Kenneth Certa, MD



Dr. Kenneth Certa is an associate professor of psychiatry at the Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia. He is currently the residency training director for psychiatry and manages emergency consults for the department. He has worked with residents and medical students seeking mental health services for many years and serves on the board of the Physician Health Plan in Pennsylvania. As a delegate from the American Psychiatric Association to our AMA, he has worked to align AMA policy with that of the APA for access and privacy for those seeking treatment. Fears of future license application questions must not be a deterrent to getting mental health care.

Christina Chapman, MD

Dr. Chapman is from Mercerville, NJ, and obtained her B.A. in Biomedical Engineering from the Johns Hopkins University and her M.D. from the University of Pennsylvania Perelman School of Medicine. After returning to Baltimore to complete internship at Mercy Medical Center in Baltimore, she completed Radiation Oncology residency at the University of Michigan, where she is currently in her third year on faculty. She treats head and neck and lung cancers at the VA Ann Arbor Healthcare system. She is a health services and health equity researcher focusing on strategies to enhance equity in access to cancer care, but also on ways to mitigate and reduce the impact of interpersonal and systematic discrimination more broadly. She has authored numerous studies on gender equity in medicine and is excited to be here today, knowing that much work still needs to be done.



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Ana Dextra



With a B.A. in Media and Cinema Studies from DePaul University and over five years of experience, Ana Dextra, has successfully helped brands authentically cultivate and communicate their identities online. Her past clients have included recording artists, music festivals, event spaces, lifestyle brands, startups, nonprofits, athletic organizations, universities and more.

Rishi Goel



Rishi Goel is in the fourth year of his MD/MPH program at the University of Texas Health Science Center in Houston. Rishi grew up in Austin, TX before attending college at Harvard University where he pursued a degree in biomedical engineering and South Asian studies. As an aspiring emergency physician, he strives to work with marginalized populations and has worked diligently to understand the structural barriers to equitable health. Outside of medicine, he has an insatiable wanderlust and loves meeting new people and new cultures.

Sara “Sally” H. Goza, MD, FAAP



Sara “Sally” H. Goza, MD, FAAP, is the 2019 President-Elect of the American Academy of Pediatrics (AAP). Dr Goza will begin her one-year term as AAP president on Jan. 1, 2020. Dr Goza is a general pediatrician and has had the privilege of taking care of children in her hometown of Fayetteville, Ga., for over 30 years. She is a managing partner in First Georgia Physicians Group.

After graduating from Rhodes College, Dr Goza attended Medical College of Georgia for her medical degree. Her internship and residency were at Cincinnati Children’s Hospital. Dr Goza is on the Community Physicians Advisory Board for Children’s Healthcare

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of Atlanta. She has been involved with the AAP Georgia Chapter for over 20 years, including serving on the Board of Directors, Medicaid Task Force and as chapter president.

Linda Hill, MD, MPH

Dr. Hill is a Professor in the Department of Family Medicine and Public Health, in the School of Medicine at UCSD. She was the founding Medical Director of the Exercise and Physical Activity Resource Center at UCSD. She is Director of the UCSD/SDSU General Preventive Medicine Residency. San Diego Family Care, a Federal 330 Community Health Center, is the site of her clinical activities, as Medical Director 1980 to 2001, and Senior Staff Physician since 2001. She is the Medical Director of the UCSD Training, Research and Education for Driving Safety (treds.ucsd.edu) and Co-Director of the UCSD Center for Human and Urban Mobility. Dr. Hill is engaged in prevention research and teaching with current/past support from the NIH, the California Office of Traffic Safety, Robert Wood Johnson, American Cancer Society, and Health Services Resource Administration, and the AAA Foundation For Traffic Safety, including research in injury prevention, driving safety, obesity, decision making, compliance, physician training, physical activity, and refugee health. Her hobbies include classical piano and ocean sports.



Alana Iglewicz, M.D.



Dr. Alana Iglewicz is an Associate Clinical Professor of Psychiatry at the University of California, San Diego (UCSD), an Associate Residency Training Director for the UCSD Department of Psychiatry, and the Advisor for Wellness at the UCSD School of Medicine. Dr. Iglewicz completed residency training in General Adult Psychiatry and subspecialty clinical and research fellowship training in Geriatric Psychiatry at UCSD. Additionally, she completed a two-year psychoanalytic psychotherapy fellowship at the San Diego Psychoanalytic Center. She is

passionate about medical education, physician wellness, and clinical approaches to loss. Dr. Iglewicz is actively involved in cross-discipline local, regional, and national efforts on physician wellness and bereavement. She is the recipient of numerous teaching and clinical awards.

Matthew Koerner



Deeply rooted in creative and product strategy, Matt is an ardent advocate for bettering healthcare through thoughtfully scaled practice innovation, cooperative strategic relationships, and implementing effective, accessible digital health tools.
Drawing on his background in advertising, product development, and co-founding a media and technology startup in Silicon Valley- he has spearheaded program and creative development with clients in medical science, technology, pharmaceuticals, consumer products, education, entertainment, and media. Prior to joining the AMA, Matt most recently served as a consultant where his work centered on brand strategy, strategic marketing communications, and creative operations frameworks for multinational clients.
Matt holds a BA in Applied Arts, BS in Interdisciplinary Studies (State Univ. of New York), and a MM in Theory (Univ. of Nevada) where his dissertation focused on scaling digital new media technology across traditionally non-interacting entities.

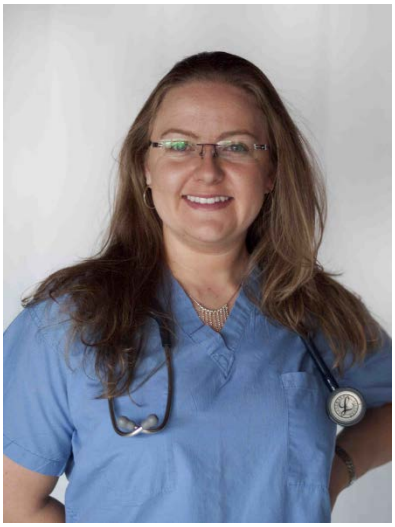
Courtney Perlino, MPP



Courtney Perlino serves as socioeconomic policy manager at the American Medical Association, where she manages a portfolio of high-profile health policy issues, including Affordable Care Act (ACA) implementation and other health reform approaches, prescription drug pricing and telemedicine. Prior to joining the AMA, Courtney worked for the American Public Health Association as a lobbyist and health policy analyst, and as a legislative aide to former Rep. Tom Petri (R-WI). Courtney received her undergraduate degree in political science and international studies from the University of Wisconsin Oshkosh and a

Master of Public Policy degree from The George Washington University.

Brandi Ring, MD, FAWM



Dr. Brandi Ring, MD, FAWM, developed a deep passion for serving the underserved and developing health policy and became an advocate for patients and physicians through her work with the American Medical Association in medical school. Dr. Ring actively advocates for her patients, her colleagues and her specialty. She can frequently be found in state and national capitols discussing health policy. Her specialty interests include high-risk and low-risk pregnancy, family planning, wilderness medicine, disaster preparation, LGBT care, well-women care and preventative health.

Mario Russo, MSE



Mario Russo is the president of Sling Health, a nonprofit student-run biotech incubator and innovation training program that has trained over 1000 students and produced over 25 companies. He currently studies medicine at Harvard Medical School and has earned his MSE and BSE in Biomedical Engineering from the University of Michigan, with a focus on medical product development. He has led multiple medical entrepreneurship projects, developing solutions aimed at benefiting the treatment of age-related macular degeneration (AMD), the treatment of postpartum hemorrhage, and the ergonomics of ERCP procedures.

Katherine M. Tynus, MD, FACP

Dr. Tynus is a primary care general internist at Northwestern Medical Group and a Clinical Associate Professor in the department of Medicine. She is a leader in academic and organized medicine.

After graduating from Northwestern University, Dr. Tynus earned her medical degree at the University of Illinois College of Medicine. She completed her internal medicine residency at Loyola University.

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She's had a long career in academic medicine, leading a successful transitional year residency program for 15 years and was awarded Gold and Silver Apple awards at MacNeal Hospital in Berwyn, IL. Dr. Tynus serves on the ACGME Transitional Year Review Committee. She wrote board exam questions as a member of the American Board of Internal Medicine Test Writing Committee for eight years. Active in organized medicine, Dr. Tynus is the Immediate Past President of the Illinois State Medical Society and a former President of the Chicago Medical Society. She serves as an alternate delegate to the AMA's House of Delegates and is on the AMA's Speaker's Panel for Practice Transformation and the STEPS ForwardTM Program.

Joey Whelihan



Joey is a third-year medical student at The University of Florida College of Medicine. He grew up in Palm Beach Gardens, FL and completed his B.S. in Biochemistry and Behavioral and Cognitive Neuroscience at UF in 2017. As an undergraduate, Joey was heavily involved in Dance Marathon and was inducted into Florida Blue Key, the oldest and most prestigious leadership honorary in the state of Florida, in 2016. His clinical interests are LGBTQ+ health, heath equity, and preventative medicine. Outside of clinic, Joey enjoys advocacy work, working out at Orange Theory Fitness, and binging the latest drama or comedy on Netflix. Joey is pursuing a career in Pediatrics.

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Kyle Yasuda, MD, FAAP



Kyle Yasuda, MD, FAAP, began his one-year term as president of the American Academy of Pediatrics (AAP) on Jan. 1, 2019.

Dr. Yasuda formerly worked in primary care pediatric practice for 18 years prior to joining the University of Washington School of Medicine where he served as clinical professor of pediatrics for 16 years and medical director of the associated pediatric clinics. For the past 3 years, he was the pediatric consultant for Public Health Seattle King County and its prevention and early intervention initiative, BestStart for Kids, that focuses on prevention and early intervention from prenatal to 24 years of age.

He has been active with the AAP for more than three decades, during which time he has served as the Washington state chapter president and various leadership roles in the AAP including chair of the AAP Committee on Practice and Ambulatory Medicine, which often is called on to comment on how policies and procedures could impact pediatricians in practice.

Dr. Yasuda was elected chair of District VIII in 2011 after serving as vice chair. His district included 12 States, Uniform Services West and 2 Canadian Provinces.

He has received the Stanley Stamm Role Model in Medicine award from the university's pediatric residency program in 2005 and the Academic Pediatric Association's Teaching Program award in 2014. He also is one of the founders of BestStart Washington, a nonprofit organization that is focusing on empowering families and caregivers to explore nature with children.

Not pictured -- Miguel Villodas, PhD; Diana Ramos, MD; Marcus Anthony; Laura Faye Gephart, MD; Sarah Mae Smith; David Welsh, MD; Michael Golding, MD.

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MSS Announcements

Message from the Chair

On behalf of the American Medical Association Medical Student Section (AMA-MSS) Governing Council, welcome to the 2019 AMA Medical Student Interim Meeting at the Marriott Marquis San Diego from Thursday, November 14, to Saturday, November 16.

This meeting is a time for medical students from around the country to debate policy, network, elect leadership and participate in shaping the future of health care. Together, our members can move medicine!

Please take the time to review the official 2019 AMA Medical Student Interim Meeting Handbook, which includes everything you will need in order to participate in all of the exciting policy debates, education programs, and networking events we have planned. The complete Handbook and other important materials are available on the AMA Medical Student Section Interim Meeting Resources webpage. There is also a meeting app available with maps and information for the meeting. Make sure to bring your laptops; we will be providing internet access to delegates, as well as extra outlets for charging. Also, be sure to join our Facebook group for AMA MSS updates throughout the year.

If this your first AMA National Medical Student Meeting then you won't want to miss the Orientation where you will learn about the AMA, how medical students make an impact on a local and national level, what to expect at the meeting, resolution writing, and parliamentary procedure.

If you have any questions, comments, or suggestions to improve our MSS Assembly meetings, please feel free to contact any Governing Council member. We look forward to working with you in San Diego! Thank you for your commitment and participation.

Sincerely,
Taylor Lucas, Chair
MSS Governing Council

Our People

MSS Governing Council

https://www.ama-assn.org/member-groups-sections/medical-students/medical-student-section-mss-governing-council

MSS Standing Committees

Committee on Bioethics and Humanities (CBH)	
Chair	Rebecca (Vanessa) Thiel
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Vice Chair	Lisa Le
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Member	Sean Cody
Member	Kayla Darris
Member	Nelly Grigorian
Member	Anna Gong
Member	Sahana Harikrishnan
Member	Arjun Kumar
Member	Adria Lam
Member	Katrina Marks
Member	Tabitha Moses
Member	Emily Scire
Member	Natasha Topolski
Member	Grace Lee

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Member	Aaron Cain
Member	Karen Chung
Member	Max Deng
Member	Ryan Englander
Member	Dora Lin
Member	Matthew Klebanoff
Member	Megan McLeod
Member	Lindsay Murphy
Member	Arpan Patel
Member	Aayush Mittall

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Member	Timothy Corwin
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Member	Anna Heffron
Member	Fatima Mirza
Member	Meeta Prakash
Member	Abigail Rentschler
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Member	Nicholas Yeisley

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Member	Jennifer Li
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Member	Samuel Roberts
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Member	Jennings Dooley
Member	Abigail Dillaha
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Member	Jessica Ludolph
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Member	Kavya Magham
Member	Rajadhar Reddy
Member	Alex Shimony
Member	Devin John
Member	Brandon Hoff
Member	Dan Schaefer
Member	Shaleen Thakur

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Member	Sneha Chebrolu
Member	Lauren Forbes
Member	Nathan Hoff
Member	Titus Hou
Member	Brianna Lally
Member	Thomas Pak
Member	Sahar Panjwani
Member	John Peterson
Member	Sneha Swaminathan
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Member	Leena Aljobeh
Member	James Cooper
Member	McKenna (Eisenbeisz) Fischer
Member	Shreya Kondle
Member	Sumayya Mohammed
Member	Rose Puthumana
Member	Dayton Snyder
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Vice Chair	Vicky Li
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Member	Taline Aydinian
Member	Elizabeth Conner
Member	Matthew Freeman
Member	Dylan Goehner
Member	Raj Kumar
Member	Aria Kamarhie
Member	Emal Lesha
Member	Jingxin Li
Member	Jay Mohan
Member	Joseph Perry
Member	Vamsi Potluri
Member	Zachary Sandman
Member	John Slunecka
Member	Samantha Spellicy
Member	Allison Young

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Chair	Madhulika (Maddy) Banerjee
Chair	Akshara Malla
Chair	Faith Mason
Member	Dory Askins
Member	Michael Bagg
Member	Matthew Belardo
Member	Arjun Chadha
Member	May Chammaa
Member	Robert Eagar
Member	Alysa Edwards
Member	Oluwasegun Emenogu
Member	Brandon Francis
Member	Amber Gautam
Member	Irraj Iftikhar
Member	Ellen Jochum
Member	Adrine Kocharian
Member	Daniel Lee
Member	Phi Luong
Member	Allie Linehan
Member	Tristan Mackey
Member	Rashmi Madhavan
Member	Justin Magrath
Member	Glen McClain
Member	Natasha McGlaun
Member	Sally Midani
Member	Maggie Oliver
Member	Aashna Patel
Member	Haritha Pavuluri
Member	Tom Plagge
Member	Manraj Sekhon
Member	Riley Shearer
Member	Vinita Shivakumar
Member	Parth Trivedi
Member	Jonathan You

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Member	Haidn Foster
Member	Cynthia Kuk
Member	Ian Maynor
Member	Austin Olano
Member	Harrison Quaal
Member	Davy Ran
Member	Stephen Werner-Sleva
Member	Leanna Knight
Member	Joey Whelihan
Member	Jason Park

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Vice Chair	Avneet Soin
Vice Chair	Sarah Joseph
Member	Yomna Amer
Member	Paige Anderson
Member	Noumi Chowdhury
Member	David Davila
Member	Angelica Gordon
Member	Tomas Hernandez
Member	Jyla Hicks
Member	Kajal Madan
Member	Danielle Rivera
Member	Anna Shvygina
Member	Alan Alvarez de Sotomayor
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Member	Clara Liu
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Member	Nikki Mitchell
Member	Pooja Nair
Member	Avani Patel
Member	Carly Polcyn
Member	Abirami Rajasegaran
Member	Julia Seiberling
Member	Mahek Shahid
Member	Emily Smith
Member	Jennifer Talbott
Member	Pavithra Wickramage

MSS Convention Committees

House Coordination Committee	
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Chair	Madhulika (Maddy) Banerjee
Chair	Akshara Malla
Chair	Faith Mason
Member	Shyama Appareddy
Member	Hetal Bhatt
Member	Lauren Forbes
Member	Rahul Iyengar
Member	Meghan Lark
Member	Swetha Maddipudi
Member	Kelsey Mumford
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Member	Jonathan You

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Vice Chair	Lisa Le
Member	Yomna Amer
Member	James Dorroh
Member	Zachary Dunton
Member	Sahana Harikrishnan

Social Media Committee	
Chair	Avneet Soin
Member	David Davila
Member	Jennifer Talbot
Member	Richard Lu

Leadership Opportunities

Applications are now being accepted for various positions; application deadlines vary. Please visit the Leadership Opportunities page on the AMA-MSS website.

Future Meetings

Annual Meeting
June 4 to 10, 2020
Hyatt Regency Chicago

Interim Meeting
November 12 to 17, 2020
Manchester Grand Hyatt

Medical Student Section Election Manual (I-19)

Candidates for Board of Trustees Medical Student Member

- Blake E. Murphy
- Sarah Mae Smith

Candidate for MSS Governing Council Chair-Elect

- Stephanie M. Strohbeen

Candidates for Regional and Alternate Delegate

REGION 1

- Neha Agrawal
- Apoorva Bhaskara
- Kevin Chu
- Alysa F. Edwards
- Drayton C. Harvey
- Meera V. Kapadia
- Akshara Malia
- Natasha Q. McGlaun
- Sally Midani
- Vinita Shivakumar
- Hank M. Spellman
- Jonathan You

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REGION 2

- Kyle S. Bevers
- Zachary R. Dunton
- Anna S. Heffron
- Titus Hou
- Rohan Khazanchi
- Raj A. Kumar
- Thomas K. Pak
- Abby E. Solom

REGION 3

- Sneha R. Aidasani
- Josh L. Bilello
- James M. Bunch
- Abhishek J. Dharan
- Anveshi G. Guha
- Shuchita V. Jhaveri
- Justin W. Magrath

REGION 4

- Dory H. Askins
- James A. Cooper
- Lauren A. Forbes
- Amber Gautam
- Daniel C. Lee
- Tristan M. Mackey
- Ian K. Motie
- Samantha M. Pavlock
- David A. Tyson

REGION 5

- Sameen Ansari
- Megan Z. Chiu
- Haidn E. Foster
- Brandon Z. Francis
- Alexander R. Thebert

REGION 6

- Arshjot S. Khokhar
- Samyuktha R. Melachuri

REGION 7

- Hussein Antar
- Parth D. Trivedi
- Leah Yuan

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AMA
AMERICAN MEDICAL ASSOCIATION

Board of Trustees Nomination Form – Medical Student

The AMA is committed to promoting diversity and inclusion in every facet of organized medicine, and encourages you to consider nominating diverse candidates such as historically underrepresented minorities, women, and international medical graduates for positions on AMA councils/committees.

AMA's Conflict of Interest Policy: Please review carefully the information provided at the end of this form.

Nominee Information

Name: Blake (First) E. (Middle Initial) Murphy (Last)

Address: 731 W. 18th Street Unit #1 (Street Address)

City/State: Chicago (City) IL (State) 60616 (Zip Code)

Telephone: 773 420 8259 (Daytime Phone) Fax: N/A

Email address: Blake.t.murphy@gmail.com / bmurphy8@luc.edu

Date of Birth: 04/01/1991 (mm/dd/yyyy) Place of Birth: Chicago, IL (City and State)

Medical School: LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

Graduated: N/A Medical Specialty: N/A

Board Certification(s): N/A

Nominee is an AMA Member: ☑ Yes ☐ No AMA Member Since: 2016

Nominee is an AMA Delegate: ☐ Yes ☐ No

Nominee has agreed to serve: ☑ Yes ☐ No

Submitted By: AJEET SINGH
Name of person/organization submitting the nomination

Email Address: ASINGH720@GMAIL.COM
Email address of person submitting the nomination

I nominate the above for the position of: BOARD OF TRUSTEES.

Supporting Information

1. Current Professional Position and Responsibilities
   (i.e. practice, administrative, research, academic)

   Third year medical student, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

2. Current/Prior State and Specialty Medical Society Memberships and Affiliations, and Faculty Appointments
   (List current and past roles and positions held and dates of service.)

   - American Medical Association (2014)
   - Illinois State Medical Society, (2014)
   - Chicago Medical Society (2014)
   - American College of Physicians (ACP)
   - American College of Emergency Physicians (ACEP)

3. Current/Prior Membership on AMA Councils/Committees:
   (List Councils or Committees and dates of service.)

   AMA House of Delegates Coordination Committee (HCC) - (JUNE 2017 - JUNE 2018)

4. Sponsor's Narrative Statement
   (Describe nominee's accomplishments and contributions using not less than 50, nor more than 250 words.)

   See attached.

5. Candidate's Statement of Interest
   (Not less than 50, nor more than 500 words.)

   See attached.

6. Endorsements
   (Are welcome, but not required.)

   Illinois State Medical Society (ISMS)

Diversity and Demographics

In order to attract the most diverse pool of candidates possible, we request the following self-reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so.**

7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions <u>are optional</u>:

Are you Hispanic?

- ☐ Yes
- ☒ No

What is your self-identified race?

- ☒ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☒ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>

- ☐ Yes
- ☒ No

Explain, if desired:

****Optional Release to External Organization Positions** – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☒ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

9. AMA's Conflict of Interest Policy

Please review carefully the AMA's Conflict of Interest Policy.

All nominees must complete a conflict of interest disclosure form between **October 16-26, 2019**. Upon the AMA's receipt of your nomination submission, an email with details on how to access the disclosure form will be forthcoming. Your nomination materials will not be considered complete until your disclosure form has been completed and returned.

If you are seeking nomination/appointment to a leadership position in another organization, please also review carefully that organization's conflict of interest policy to determine that you will be able to comply. Please also familiarize yourself with the other organization's requirements/instructions for completion of any disclosure form.

If you have questions about the AMA's Conflict of Interest Policy, the AMA's Office of General Counsel (ogc@ama-assn.org) is available to provide guidance.

Please confirm, by signing below, that you have reviewed the AMA's Conflict of Interest Policy and Principles, and understand the guidance provided above.

Signature

10/12/2019.
Date

Medical Student Section Addendum

Please also submit the following items:

1. **Candidate's Statement of Interest**

Submit a statement of interest (no more than 2 pages) detailing your reason for wanting to become a member of the AMA-BOT, the exceptional qualities/qualifications you possess that will enable you to serve effectively, your perception of the role of the student member of the AMA-BOT, what important issues are currently facing medical students and the medical profession, how you would prepare yourself (i.e., become knowledgeable) to address these issues, including what resources you would use, and what suggestions for AMA action you might have.

2. **Current Curriculum Vitae (no more than 3 pages) which includes Current/Prior Leadership Positions**

Include current and prior leadership positions with titles, dates of service, and notable responsibilities.

3. **Sample Memo**

Write a sample memo to the Chair of the AMA-BOT persuading him or her to endorse and support the AMA-MSS in an issue that you have identified as significant to the MSS. Please be specific on the issue and the action you would like the Board to take.

4. **Endorsements/Letters of Recommendation**

Your Speakers will allow the inclusion of 2 optional letters of endorsement in the Elections Manual: one optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in, and one optional letter of endorsement by staff of the state society from the state the candidate attends medical school. No other letters of endorsement may be included in the Elections Manual.

5. **Dean's Signature**

Please acknowledge that you have discussed this time commitment and made appropriate arrangements with your dean or clinical preceptor by signing the document attached below.

6. **Electronic Photo**

Include a copy of an electronic photo that will appear in the election manual.

7. **Internal Operating Procedures and Speaker's Ruling**

It is a requirement for all candidates to review the Speaker's Ruling in its entirety before beginning their respective campaigns. Follow these links to find the AMA MSS Internal Operating Procedures and Speakers' Ruling.

Please e-mail your application and accompanying materials to mss@ama-assn.org no later than October 13, 2019 at 1:59AM CT.

Of note, if you are elected to this position, you'll be invited to join the rest of the Governing Council at a welcome dinner the evening of Saturday November 16, 2019!

10/11/2019

Acknowledgment of Time Commitment and Confirmation of Good Standing

Please acknowledge that you have discussed the time commitment for this position and made appropriate arrangements with your dean or clinical preceptor by signing below. The signature of your Dean or Advisor is required (1) to acknowledge the time commitment involved in a Board of Trustees position and (2) to verify that you are a student in good-standing with your medical school.

Candidate Signature: _____

Medical School Dean or Advisor Signature: James G. Mendy, PhD

Blake Elizabeth Murphy

731 W. 18th Street, Chicago, IL 60616 | blake.e.murphy@gmail.com | (773) 420-8259

EDUCATION

Jun. 2016 - May 2021 **STRITCH SCHOOL OF MEDICINE AT LOYOLA UNIVERSITY** Maywood, IL
M.D. Candidate, Class of 2021

Sep. 2009 - Jun. 2013 **NORTHWESTERN UNIVERSITY** Evanston, IL
Bachelor of Arts in Psychology

ORGANIZED MEDICINE EXPERIENCE

AMERICAN MEDICAL ASSOCIATION

Aug. 2019 **Health Equity Fellow – Center for Health Equity** Chicago, IL

- Worked alongside Chief Health Equity Officer to develop infrastructure and strategy for implementation of AMA policy related to the newly-created Center for Health Equity
- Collaborated with AMA staff across multiple business units to provide health equity perspective for incorporation into short-term and long-term project goals and expectations

Jun. 2018 - Jun. 2019 **Government Relations Advocacy Fellow** Washington, DC

- Worked in the AMA's federal advocacy office for yearlong fellowship which included completing background research on health policy subject matter, drafting letters to Congress and U.S. Federal agencies, and attending congressional briefings
- Planned weeklong grassroots advocacy campaign for 56,000 medical students, advocating for support of DACA students, increased access to MAT for OUD/SUD, and lower drug pricing
- Organized three-day advocacy conference in Washington, DC for 375 medical students, which required scheduling 225 congressional visits, developing programming, and coordinating the invites for four congressional speakers
- Traveled to 35-40 medical schools across the country to discuss AMA's advocacy efforts and opportunities for medical student engagement at the chapter, state, and national level

Jun. 2017 - Jun. 2018 **Advocacy Chair – AMA Medical Student Section** Chicago, IL

- Elected by Region 2 medical students to lead advocacy efforts and assist in the resolution review
- Facilitated region-wide advocacy events during AMA MSS National Advocacy Week, updated chapter leaders about healthcare policy, and acted as liaison for persons with developing interest in advocacy

Jun. 2017 - Jun. 2018 **House of Delegates Coordination Committee – AMA MSS** Chicago, IL

- Member of AMA-MSS committee that reviews all resolutions submitted to Interim and Annual meetings within AMA Medical Student Section and broader House of Delegates
- Developed the ability to comprehensively review AMA-MSS and AMA policy, while working in team-based environment to efficiently coordinate the official positions of the Section based on research and analysis

Jun. 2017 - Jun. 2018 **Delegate – AMA-MSS Chapter Delegate** Chicago, IL

- Compiled summary of resolutions to be presented at AMA-MSS 2017 Annual meeting to facilitate discussion as it related to school position regarding individual subject matter

Jun. 2017 - Jun. 2018 **Chapter President – Stritch School of Medicine** Chicago, IL

- Advocated on behalf of the SSOM student community on issues ranging from protecting the Affordable Care Act (ACA) to protection for medical students with DACA status, and organized week-long set of activities for students including naloxone trainings and visits with U.S. Senators and Representatives

ILLINOIS STATE MEDCIAL SOCIETY

June 2017 - June 2018 **Council on Membership and Advocacy** Chicago, IL

- Collaborated with Illinois State Medical Society physicians to determine strategies to retain and increase student and physician membership
- Developed and expanding membership value by increasing awareness of resources, benefits, and service offered by the Illinois State Medical Society

PROFESSIONAL AND LEADERSHIP EXPERIENCE

OAK STREET HEALTH

Oct. 2015 - Jun. 2016 **Medical Economic Analyst** Chicago, IL

- Collaborated with members of the Medical Economics team to build an organization-wide reporting system for patient admission, risk scores, and specialist costs for 15,000-person patient panel
- Created a dynamic dashboard to categorize and track activities created in Care Management software by social workers in clinical care teams, while working with NPs to improve billing and coding practices

Jun. 2015 - Oct. 2015 **Clinic Informatics Specialist** Chicago, IL

- Acted as personal assistant to physician during patient interactions within primary care setting, managed tracking of preventative care medical records, organized clinical schedule
- Worked with clinical and service team to navigate issues concerning workflow during the clinic opening process and establishment of a growing patient panel

KAPPA ALPHA THETA

Jan. 2012 - Jan. 2013 **Chief Operating Officer/Vice President of Development** Evanston, IL

- Served as Chairman of the Membership Development Committee, a group within the chapter that worked on improving the physical, emotional, mental and academic wellbeing of the chapter
- Implemented risk management programming within the chapter as Chairman of the Risk Management Team, improving the oversight and conduct at various chapter events

GLOBAL BRIGADES: PUBLIC HEALTH BRIGADES

Sep. 2010 - Jun. 2012 **President of Public Health Brigades** Evanston, IL / Tegucigalpa, Honduras

- Collaborated with local teachers, families, and students to integrate educational programming for the improvement of public health standards in rural Honduran communities
- Coordinated travel arrangements, itineraries, trip advising, and vaccination information for students traveling to Honduras

VOLUNTEER EXPERIENCE

Nov. 2016 - May 2017 **HEALTH CAREER ACADEMY (HCA)** Maywood, IL

High School Mentor, Stritch School of Medicine

- Worked with and mentored high school students weekly in the local Maywood community, over three-month time period about basic science principles introduced in first year curriculum including first aid

Sep. 2014 - May 2015 **COMMUNITY HEALTH CHICAGO** Chicago, IL

Triage Volunteer

- Learned basic triage skills necessary for medical evaluation for underserved and uninsured patient populations on west-side of Chicago

Jan. 2014 - Jan. 2015 **LURIE CHILDREN'S HOSPITAL OF CHICAGO** Evanston, IL
Bedside Volunteer

- Worked for Child Life Specialists to provide comfortable conditions for pediatric patients suffering from severe respiratory illness

Jan. 2013 - May 2013 **CENTER ON WRONGFUL CONVICTIONS AT NORTHWESTERN UNIVERSITY** Chicago, IL
Research Intern

- Researched, organized, and summarized cases of wrongful conviction for Research Database on Wrongful Convictions developed by Bluhm Legal Clinic at Northwestern University

RESEARCH EXPERIENCE

PUBLICATIONS

Ryan Chiu BS, Blake Murphy BA, David Rosenberg BS, Amy Zhu BS, Ankit Mehta MD (August 2019). *Does Hospital For-Profit Status Affect Intracranial Hemorrhage Outcomes and Cost of Care?* Neurosurgery. DOI: 10.1093/neuros/nyx310_320

PRESENTATIONS

Blake Murphy BA, Mary Varsanik BS, James Neelon BS, Megan Rech PharmD, Shannon Lovett MD. (October 2019). *Impact of Heart-Risk HEART Score on Readmission Rates, Observation Unit Utilization, and Length of Stay in Emergency Department.* American College of Emergency Physicians, Denver, Colorado (Oral)

Christine Thomas DO, Blake Murphy BA, Brendan Martin PhD, William Adams PhD, Tania Torres MD, Laura Ozark MD (April 2019). *Factors Implicated in Thoughts of Suicide and Self-Harm Among Medical Students.* American College of Physicians, Philadelphia, Pennsylvania (Poster)

Christine Thomas DO, Blake Murphy BA, Tania Torres MD, Brendan Martin PhD, William Adams PhD, Laura Ozark MD (October 2018). *Depression Among Medical Students and Protective Factors.* Internal Conference on Physician Health, Toronto, Canada (Poster)

Ryan Chiu BS, Blake Murphy BA, David Rosenberg BS, Amy Zhu BS, Ankit Mehta MD (October 2019). *Does Hospital For-Profit Status Affect Intracranial Hemorrhage Outcomes and Cost of Care?* American College of Surgeons, San Francisco, CA (Poster)

Ryan Chiu BS, Blake Murphy BA, David Rosenberg BS, Amy Zhu BS, Ankit Mehta MD (October 2019). *Racial and Ethnic disparities in the inpatient management of primary spinal cord tumors within the United States: a nationwide all-payer analysis.* American College of Surgeons, San Francisco, CA (Poster)

Ryan Chiu BS, Blake Murphy BA, David Rosenberg BS, Amy Zhu BS, Ankit Mehta MD (September 2019). *Does Hospital For-Profit Status Affect Intracranial Hemorrhage Outcomes and Cost of Care?* Illinois State Neurosurgical Society, Chicago, IL (Oral)

Ryan Chiu BS, Blake Murphy BA, David Rosenberg BS, Amy Zhu BS, Ankit Mehta MD (September 2019). *Racial and Ethnic disparities in the inpatient management of primary spinal cord tumors within the United States: a nationwide all-payer analysis.* Illinois State Neurosurgical Society, Chicago, IL (Oral)

INTERESTS

International travel, craft cocktails, long-distance running, photography, golfing, yoga, snowboarding

LOYOLA MEDICINE
Loyola University Chicago Stritch School of Medicine

October 13, 2019

American Medical Association (AMA)
mss@ama-assn.org

Re: Blake Murphy Letter of Recommendation for the AMA Board of Trustees Student Position

Dear Board of Trustees:

I am writing to you on behalf of Blake Murphy to support her application for the AMA Board of Trustees student position. Blake is an excellent student who is committed and driven to be an exceptional physician, and I strongly support her nominee for the position.

Blake is a third-year medical student who matriculated at the Loyola University Chicago Stritch School of Medicine in July 2016. I have known her in my capacity as Associate Dean for Student Affairs at Loyola and I find her to be a very serious, thoughtful, and engaging person. At Stritch, Blake has shown herself to be a diligent student with other personal interests. She is in good standing, is making excellent progress in the MD curriculum to date, and is expected to complete her M.D. requirements and graduate in May 2021.

Blake's extensive engagement with the AMA as a proven student leader makes her an exceptional candidate to serve on the AMA Board of Trustees. These experiences include the following: *Health Equity Fellow at the Center for Health Equity; Government Relations Advocacy Fellow*; *Advocacy Chair – AMA Medical Student Section; House of Delegates Coordination Committee – AMA Medical Student Section; Delegate – AMA-MSS Chapter Delegate; Chapter President – Stritch School of Medicine.*

Blake is demonstrating the acquisition of knowledge, skills and professional attributes needed to be both a scholar and a capable, caring physician. She embodies the requisite leadership and organizational skills to be a valuable member of the AMA Board of Trustees. In addition, she has an outgoing personality, is very results oriented, and has the ability to articulate her purposes and values. As her dean, I give her my strongest recommendation for your consideration for this prestigious position.

If you have any questions or need additional information, feel free to contact me at the phone number listed above or via e-mail (jamendez@luc.edu).

Sincerely,

James G. Mendez, Ph.D.
Associate Dean, Student Affairs
Assistant Professor, Medical Education

Illinois State Medical Society

October 9, 2019

To Whom It May Concern:

I am writing this letter on behalf of the Illinois State Medical Society in support of Ms. Blake Murphy as she pursues the position of Student Trustee on the Board of Trustees within the American Medical Association (AMA).

As a first-year medical student, Ms. Murphy showed her passion for the policy side of healthcare and joined the Illinois State Medical Society (ISMS) and the American Medical Association (AMA) at the Loyola Stritch School of Medicine. Ms. Murphy served as president of Loyola's AMA/ISMS student organization on campus, in addition to being Loyola's elected delegate to the ISMS during 2017-2018. She demonstrated leadership and active involvement by attending conferences, organizing advocacy workshops, and developing state, regional, and national connections for the Loyola chapter. She was dedicated to truly understanding and teaching others about the organizational structure and procedures of organized medicine, which facilitated the involvement of fellow students at her campus and within Illinois.

Most recently, Ms. Murphy has served as the Government Relations Advocacy Fellow (GRAF) within the AMA for 2018-2019. In this position, Ms. Murphy served as a member of the AMA's advocacy team stationed in Washington D.C. and was responsible for researching policy issues related to healthcare and medical education, promoting engagement in medical student advocacy by traveling to medical schools to share her experiences, and providing advocacy updates to the MSS by way of in-person presentations, as well as developing marketing collateral about the public health issues being addressed by the AMA. Some of Ms. Murphy's most notable achievements while serving as the GRAF are listed below:

- Visited more than 35 medical schools across the country to discuss the AMA's advocacy efforts and opportunities for student engagement at the chapter, state, and national levels;
- Planned a week-long, grassroots advocacy campaign for 56,000 medical students, which included advocating for specific pieces of legislation related to access to medication-assisted treatment (MAT) for opioid-use disorder and substance-use disorder, and lowering of prescription drug prices;
- Created a 12-page toolkit that was supplied to AMA chapters with information on how to organize events and schedule visits with district and congressional representatives/senators;
- Planned a three-day advocacy conference in Washington, D.C. for 375 medical students, including the scheduling of 225 visits in the House of Representatives and Senate, two days of programming sessions, and organizing four speakers;
- Served as contact for medical students with advocacy related questions, and reviewed 25-40 MSS resolutions for AMA Interim and Annual Meetings;

Twenty North Michigan Avenue, Suite 700 Chicago, IL 60602 Web site: www.isms.org
Telephone: 312-782-1654 Toll Free: 800-782-4767 Fax: 312-782-2023

- Attended congressional briefings and events on health policy, such as graduate medical education, drug pricing, Medicare/Medicaid, data privacy, and health system reform, on behalf of the AMA advocacy staff;
- Briefed the AMA's Council on Legislation (COL) on federal GME and physician workforce updates on a quarterly basis; and,
- Assisted and drafted letters to Congress, and federal agencies on GME and physician workforce related issues.

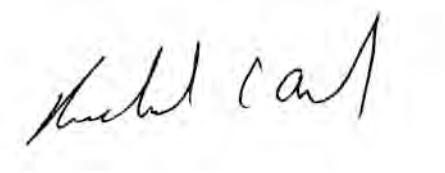
The overall purpose of this position is to educate medical student, resident and young physicians about issues in public health and health policy in order to encourage activism and leadership in local communities, and Ms. Murphy did just that. We are proud of Ms. Murphy's accomplishments during her time as the GRAF, as well as the way she represented the Illinois State Medical Society while serving in this capacity.

As shown in her CV, Ms. Murphy has a range of additional experience and knowledge she would be able to bring with her to the trustee position. As demonstrated through her involvement within the ISMS and the AMA, Ms. Murphy understands and appreciates the importance of healthcare policy. Furthermore, Ms. Murphy is approachable, adaptable and sincere in her interactions with her colleagues, which will be a vital skill set for the Trustee position. To say Ms. Murphy is a committed advocate for physicians and their patients would be an understatement.

I sincerely believe Ms. Murphy can and will continue to do much more in the public health arena to better the practice of medicine for physicians and their patients, and that she will be a valuable member of the AMA's Board of Trustees.

Please contact me at DrRAnderson@isms.org, should you like to discuss further Ms. Murphy's qualifications and experience.

Sincerely,



Richard C. Anderson, MD
Chair, Board of Trustees
Illinois State Medical Society

Enclosure
cc: Paul E. Pedersen, M.D.
Robert W. Panton, M.D.
Shastri Swaminathan, M.D.
Nestor A. Ramirez, M.D., M.P.H.
Alexander R. Lerner



MEMORANDUM

To: Dr. Jesse M Ehrenfeld, MD, MPH
Chair, AMA Board of Trustees

From: Blake Elizabeth Murphy

Subject: Empowering the Next Generation of Physicians

Dear Dr. Ehrenfeld,

On behalf of the 55,000 medical student members of the American Medical Association, I am writing to propose strategies for improving resident training opportunities through Graduate Medical Education (GME) funding and physician workforce expansion. During my time serving as the AMA's Government Relations Advocacy Fellow (GRAF), I developed a comprehensive understanding of how our organization implements the policy we pass at our Interim and Annual meetings.

My time in Washington, D.C. also provided a dedicated space to learn about the fiscal intricacies of GME infrastructure, related legislation, and the power of grassroots advocacy. During the planning and execution of the 2019 Medical Student Advocacy and Region Conference (MARC), student attendees felt overwhelmingly empowered to advocate for the residency training positions the profession needs at this critical juncture. Although my colleagues and peers inspired great confidence during their legislative visits, I recognize the call to action would benefit greatly from renewed physician support and active endorsement.

While the AMA continues to champion medical education through congressional lobbying efforts, the Accelerating Change in Medical Education (ACE), and Reimagining Residency initiatives, there exist opportunities for optimization of internal collaboration and external coalition-building. As an AMA member and third year medical student, I believe our organization can spearhead the charge in solving the physician shortage crisis. Our patients and the next generation of physicians depend on it.

OVERVIEW

The Physician Shortage Crisis

The most recent reports released by the American Association of Medical Colleges (AAMC) finds that physician demand will continue to outpace supply, with projected physician shortfalls between 46,900 and 121,900 physicians by 2032. There is an expected shortage of 21,100 to 55,200 primary care physicians, 24,800 to 65,800 non-primary care specialty physicians, and 14,300 to 23,400 surgeons.[1]

The analysis found that projected physician shortages would also increase substantially if underserved patient populations had care utilization patterns similar to those with fewer access barriers. The primary drivers of increasing physician demand include population growth and aging and the prioritization of population health goals within medical practice. Meanwhile, the primary determinants of physician supply include considerations such as an anticipated wave of retirement across the physician workforce and trends toward fewer weekly hours worked by current

practicing physicians. It is important to note that supply modeling assumed the Resident Physician Shortage Reduction Act of 2019 would be enacted into law, which to date has not passed committee introduction in the Senate (S. 348) and House of Representatives (H.R. 1671).

Regarding current physician shortages, the Health Resources and Services Administration (HRSA) estimated 78 million people living in primary medical health professional shortage areas (HPSAs) as of October 2019. Approximately 14,461 practitioners are needed to remove the HPSA designation, specifically for primary care. Currently, HPSAs only take into physician shortages within primary care, mental health, and dental specialties.[2] The rising deficiencies in the physician workforce is problematic, as evidence has demonstrated that states with more physicians per-capita, both specialists and family physicians, have better-quality health care.[3]

Availability and Funding of Residency Positions

In response to concern of physician oversupply, Congress enacted the Balanced Budget Act of 1997. The legislation limited the number of federally-funded residency positions available for medical school graduates and physicians-in-training. However, by 2006 the AAMC was calling for medical schools to increase medical school enrollment by 30% within the following decade. In combination with first-year matriculation at osteopathic medical schools, medical school enrollment is now 52% higher than in 2002-2003, without a corresponding increase in available residency positions.[4] According to the 201 NRMP Match Results and Data, there were 32,194 post-graduate year (PGY)-1 positions and nearly 44,603 applicants -- a staggering surplus of 12,409 medical student graduates relative to the available residency spots.[5]

The federal government continues to serve as the majority contributor for GME funding. Payment from Medicare, Medicaid, the Teaching Health Centers GME Payment Program, Children's Health GME Payment Program, the Department of Defense, and the Veteran's Affairs Administration all support GME. According to reports released by the U.S. Government Accountability Office (GAO), spending through federal agencies and state Medicaid agencies totals over $16 billion, as of 2015.[6] Some hospitals have been able to expand the number of residents they are training through ancillary sources such as institutional, local, state, and philanthropic funding. However, this private residency position expansion has often occurred in subspecialties that generate higher revenue at lower costs.

The Medical Student Reality

With a yearly surplus of over 12,000 applicants to available positions, residency matriculation has become increasingly competitive. The rising cost to attend medical school does not ease the pressure physicians-in-training experience during their undergraduate medical education (UME) career. According to the AAMC, in October 2018 medical students graduated with an average debt burden of $188,758 and $209,367 for public and private institutions, respectively.[7] It is no surprise that the newest generation of physicians are suffering from unprecedented levels of depression and burnout. Medical students often cite busy school workloads, performance pressures, lack of work-life balance, career planning, and financial concerns as the common contributors to feelings of anxiety, depression, and burnout.[8] Some estimates suggest that nearly 50% of students experience symptoms of burnout during medical school.[9] These findings extend throughout the medical career continuum, with studies demonstrating reduced satisfaction and increased burnout in U.S. physicians when compared to the general population.[10]

I'm proud to be a part of an organization that has sought to tackle the issue of medical student, resident, and physician burnout by leading by example. The AMA's Reimagining Residency Initiative has created incentives for programs to promote well-being for trainees and their colleagues in the learning environment, as a strategic area of focus for innovation projects.[11] However, I believe this landmark commitment to addressing the issue of residency well-being must seriously considered in the context of the aforementioned systemic stressors.

Legislative Updates

In the 116th Congress (2019-2020), the AMA has supported for several federal bills related to graduate medical education and the physician workforce. The Community and Public Health Programs Extensions Act (S. 192), would authorize $310 million for the National Health Service Corps, $126M for the THCGME programs, and $4 billion for Community Health Centers for each fiscal year from 2019 to 2024.[12] As reference above, the Resident Physician Shortage Reduction Act of 2019 (S. 348/H.R. 1793) would provide 15,000 additional Medicare-supported GME positions over five years. The Opioid Workforce Act (H.R. 2439) would add 1,000 Medicare-supported GME positions in addiction medicine, addiction psychiatry, and pain management.[13] The Advancing Medical Resident Training in Community Hospitals Act (H.R. 1358) would close a loophole in GME-setting criteria affecting hospitals who host small numbers of residents for temporary training assignments.[14]

While these pieces of legislation have garnered formal support from the AMA, all but one, the Opioid Workforce Act (H.R. 2439) have passed their respective chambers of Congress. Although the Resident Physician Shortage Reduction Act is the most comprehensive proposal for GME expansion efforts, the bill was first introduced in 2013 and has struggled to garner congressional support for nearly five legislative sessions.

Over the past several years, the AMA has also interacted closely with the Health Professions and Nursing Education Coalition (HPNEC), which is considered an informal alliance of more than 65 organizations representing a variety of schools, programs, health professionals, and students dedicated to education-based health personnel. The members of HPNEC advocate for adequate and continued support for the health professions and nursing workforce development programs authorized under Title VII and Title VIII of the Public Health Service Act (PHSA). Title VII of the Public Health Service Act (PHSA) specifically supports physicians, allied health professionals, and applicable faculty through a variety of programs related to loan repayment, diversity and inclusion, and mental health, behavioral health, public health, preventative health, SUD, and primary workforce development.[15]

AMA Grassroots Resources

The AMA create the SaveGME.org website in 2013 as a grassroots advocacy platform used by medical students and residents. The website was utilized as a reference point when lobbying lawmakers in favor of preserving essential GME funding. The microsite was most recently updated in 2017 to include public facing messaging and educational materials. The AMA-MSS annually hosts the Medical Student Advocacy and Region Conference. Approximately 400 medical students participate in three-day advocacy event which offers students the opportunity to learn about GME-related legislation and lobby their members of Congress.

RECOMMENDATIONS

1. Update Grassroots Resources and Physician Engagement

Medical students, residents, and physicians alike benefit from access to resources that inform and educate. The Board of Trustees should seek to update existing resources such as the SaveGME website and its affiliated or hyperlinked microsites. Additional consideration should be given to the development of educational materials that can be downloaded directly from the AMA website. Not all students get to participate in AMA conferences in which high-yield content is distributed, but should have access to the information that teaches students about the importance of GME funding, offers advice for organizing and lobbying, and empowers students to speak on the issue to colleagues, medical school administrators, physician mentors, and legislators.

2. Increase Physician Engagement

The Board of Trustees should also consider opportunities for engagement by the physician members of the AMA on the issue of GME funding. The Annual AMA National Advocacy Conference (NAC) which takes place in Washington, DC is an optimal time to engage physicians who meet with their congressional senators and representatives. The show of support from medical students and physicians would positively impact advocacy and policy implementation efforts.

3. Elevate Public Interest in GME

In the past few years, the AMA has been known for protecting the Affordable Care Act, tackling the Opioid Epidemic, and calling for common sense gun violence prevention. Seen as the representative voice of America's medical student and physician community, the AMA sets the tone for conversation and discourse in the health policy space. In order to push forward efforts to expand GME, the Board should consider increasing how we engage the public in communicating the role GME in the American healthcare system. Additionally, mobilization of the public outside of our industry elevate the importance of expanding these programs for elected officials.

4. Join Coalitions That Further GME Priorities

Coalitions are essential to the success of our policy implementation efforts, particularly in our nation's Capitol. The Board of Trustees should consider whether to officially join coalities such as the Health Professions and Nursing Education Coalition (HPNEC) which is dedicated to tackling issues such as loan repayment, diversity and inclusion, and workforce development.

5. Strengthen Relationships With AAMC and ACGME

The Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) are both organizations that have resources and personnel dedicated to expanding GME funding and supporting the physician workforce. The Board of Trustees should consider more active engagement with these organizations when developing programming for AMA events and calling for action on shared policies of interest. In order to obtain success in comprehensively expanding GME funding and resources, we must lean on our allied partners and colleagues to present a representative and unified voice.

Thank you for your time and consideration.

Sincerely,



Blake Elizabeth Murphy
MD Candidate, Loyola Stritch School of Medicine

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Sponsor's narrative statement

I am writing to provide my strongest recommendation for Blake Murphy in the role of Trustee for the American Medical Association. I have worked with Blake for the past 3 years in various capacities, and I am delighted to support such an exceptionally qualified candidate for this position.

From the start of her tenure, was clear that Blake would be an impactful leader within the MSS and an invaluable asset to the AMA's broader community. Since then, we have witnessed unprecedented challenges to our efforts in improving healthcare, and Blake has consistently proven herself more than capable. As a tenacious advocate, she welcomed opportunities to dive deep into esoteric nuances in policy, relentlessly following the evidence and always staying true to her values. In all of her pursuits, she has listened to and elevated the voices of her colleagues, effortlessly building relationships with students and physicians from around the country. Her passion for education and engagement has also made her an insightful mentor to many- students trust her not just as an impressive authority on health policy, but also as an honest and genuine friend.

For these reasons and more, I could not imagine a better candidate to join the AMA Board of Trustees.

Ajeet Singh

BLAKE FOR BOARD

An Advocate for the Medical Student Voice



Blake Elizabeth Murphy | *An Introduction*

I'm a third-year medical student at the Stritch School of Medicine and a seasoned leader in the AMA. This November, I'm asking you to elect me as the next student member to the Board of Trustees. In the years to come – and especially next year – medical students, physicians, and patients will be impacted by changes to our healthcare system at both the local and national level. The American Medical Association must vigorously advocate for the practice of medicine and the betterment of public health, now more than ever.

Having spent a year in Washington, D.C. with the AMA's federal advocacy department, I know what advocacy looks like. I understand the challenges we face in ensuring that our patients are protected. I've worked alongside the experts who implement the policy we pass at our meetings. And, I've brought the student voice to every conversation I've had on and off the Hill. I am, and will always be, an advocate for my patients, my colleagues, and the next generation of medical students and physicians.

Together, we are the future of medicine.

From Medical School to Our Nation's Capital | *My Unparalleled Experience*

My positions within the MSS, Advocacy department, and Center for Health Equity have provided me with an intimate understanding of the AMA. I want to put my experience to work for you and for our Section.

MSS Operations

Upon joining the AMA, I served as my school's chapter President, Region 2 Advocacy Chair, and member of the House of Delegates Coordinating Committee (HCC). These positions offered time to develop experience and build relationships at my school chapter, in my region, and on an MSS committee.

Policy and Political Expertise

During my year-long fellowship in Washington, D.C. I learned how to turn policy into action, the importance of coalition-building, and the weight of the AMA's national influence. From reviewing MSS resolutions to attending hearings on the Hill, I was directly involved in the AMA's nationwide efforts to support our members through federal, state, and grassroots advocacy. I was immersed in some of the most important issues facing healthcare today, including GME, surprise billing, drug pricing, and health system reform.

A Health Equity Lens

Most recently, I served as an intern at the AMA's new Center for Health Equity after collaborating directly with our Chief Health Equity Officer, Dr. Aletha Maybank, during my GRAF tenure. Through the internship, I gained a unique understanding on how the AMA will incorporate the health equity perspective into work across all of the AMA's business units. As a member on the Board of Trustees, I will put my health equity experience to work for our patients, for our section, and for the betterment of our organization.

Learn more about my time in Washington, D.C. here or at http://rebrand.ly/ShakeAndBlake.

BLAKE FOR BOARD ***#ShakeAndBlake.***

An Advocate for Students, An Advocate for Change | *My Priorities*

Graduate Medical Education

Every candidate runs on the issue of graduate medical education, but for me, it's different. Now is the time to make GME more than just a medical student priority. During my time as GRAF, I attended congressional briefings, advised the AMA's Council on Legislation, wrote letters to Congress, and planned a three-day advocacy conference around the issue of GME funding and expansion of the physician workforce.

As Trustee, I will work to make conversations about GME more than just a talking point. Moving forward, I will advocate for comprehensive updates to the SaveGME website, greater prioritization of our efforts on Capitol Hill, and the development of grassroots resources for students across the United States.

Federal Healthcare Reform

Over the past three years, ongoing legislative and regulatory challenges to the Affordable Care Act have resulted in a higher uninsured rate, rising premiums, and significant insurance market instability. As national discourse around health system reform evolves, medical students and physicians should not only have a seat at the table, but rather lead the conversation.

As Trustee, I will bring my policy and political expertise directly to the boardroom, ensuring that MSS values are communicated while considering new proposals for health care delivery. I also recognize the opportunities for further membership education, and will work to make programming and engagement accessible across AMA platforms.

Health Equity

The AMA defines health equity as optimal health for all, with the goal of advocating for health care access, research and data collection, promoting equity in care, increasing health workforce diversity, influencing the social determinants of health, and modeling commitment to health equity. Elevating the conversation around health equity requires creating inclusive spaces for discourse across the medical education continuum.

As Trustee, I will advocate for resources to educate the medical community about the challenges in addressing structural racism and for the development of partnerships reinforcing our dedication to these objectives. I will never be afraid to engage in the hard conversations required to achieve optimal health for all.

Supporting the MSS | *My Priorities*

Empowering the Medical Student Voice

As a fierce coalition of nearly 55,000 leaders and physicians-in-training, the MSS has taken on some of the most pressing issues facing healthcare today. Our section not only benefits from a robust policy-making process, but a` tremendous organizing capacity.

As Trustee, I will ensure that the Board better understands the benefit of student involvement, our tenacious passion and unmatched productivity. Working alongside our elected Governing Council members, I will relentlessly advocate for the health and well-being of our section. I promise to reinforce our priorities and magnify medical students' influence across the organization.

Increasing Communication and Collaboration

Every medical student knows the excitement surrounding your first AMA meeting. These moments are made possible by strong student leadership and our tremendous AMA staff behind the scenes. And, between meetings, continuing engagement requires consistent outreach to students and chapters.

As Trustee, I want to make communication more reliable, advocacy resources more accessible, and grassroots engagement more impactful. I will continue to work alongside the MSS GC and AMA staff as I did last year to fulfill the strategic priorities set by our leaders. The more we know, the more we can accomplish.

Being a member of the MSS has been the greatest privilege during my time in medical school. As a Board member, I plan to drive meaningful impact through advocacy, relationship-building, and informed discourse. We are at the precipice of great change in medicine and in healthcare delivery, and we need strong leaders to advocate for our values. I hope you will give me the opportunity to represent our voice, our perspective, and our passion on the Board of Trustees.

It's time to **#ShakeAndBlake.**

Sincerely,



Board of Trustees Nomination Form – Medical Student

The AMA is committed to promoting diversity and inclusion in every facet of organized medicine, and encourages you to consider nominating diverse candidates such as historically underrepresented minorities, women, and international medical graduates for positions on AMA councils/committees.

AMA's Conflict of Interest Policy: Please review carefully the information provided at the end of this form.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY October 4, 2019 at 11:59pm Pacific Time

Nominee Information

Name:	Sarah (First)	Mae (Middle Initial)	Smith (Last)
Address:	Unit 3060, 1801 East Katella Avenue (Street Address)		
City/State:	Anaheim (City)	California (State)	92805 (Zip Code)
Telephone:	(518) 496-5895 (Daytime Phone)	Fax:	
Email address:	ssmith2@hs.uci.edu		
Date of Birth:	11/25/1990 (mm/dd/yyyy)	Place of Birth:	Ithaca, New York (City and State)
Medical School:	University of California, Irvine School of Medicine		
Graduated:	N/A	Medical Specialty:	N/A
Board Certification(s):	N/A		

Nominee is an AMA Member:	☒ Yes	☐ No	AMA Member Since: 2013
Nominee is an AMA Delegate:	☐ Yes	☒ No	
Nominee has agreed to serve:	☒ Yes	☐ No	

Submitted By:	**Sarah Mae Smith** (Name of person/organization submitting the nomination)
Email Address:	ssmith2@hs.uci.edu (Email address of person submitting the nomination)

I nominate the above for the position of: AMA Board of Trustees

Supporting Information

1. Current Professional Position and Responsibilities
(i.e. practice, administrative, research, academic)

I am a seventh-year MD/PhD student at the University of California-Irvine's Medical Scientist Training Program, completing my PhD dissertion in the laboratory of Dr. Charles Limoli. I am studying the iatrogenic effects of chemotherapy and irradiation on neurological function, and potential stem cell-based therapies to ameliorate associated deficits.

2. Current/Prior State and Specialty Medical Society Memberships and Affiliations, and Faculty Appointments
(List current and past roles and positions held and dates of service.)

California Medical Association, 2013 to Present: CMA Council on Medical Services, October 2016 to Present; CMA Delegate to the AMA, November 2017 to November 2018; CALPAC Board of Directors, March 2018 to October 2018 and January 2015 to December 2015; CMA Council on Ethical, Legal, and Judicial Affairs, October 2015 to October 2016; CMA Reference Committee E (Quality, Ethics, and Medical Practice Issues), October to December 2014; CMA Council on Legislation, February 2014 to December 2014

3. Current/Prior Membership on AMA Councils/Committees:
(List Councils or Committees and dates of service.)

Board of Trustees, June 2019 to Present; Council on Medical Service, June 2017 to June 2019 (Chair of the Council's Committee on Health System Reform, June 2018 to June 2019); Medical Student Section Delegate (Governing Council), June 2016 to June 2017; Reference Committee C (Medical Education) Member, Annual 2016; AMA-MSS House of Delegates Coordinating Committee Chair, July 2015 to June 2016 (Member, July 2014 to June 2016); Region 1 Delegate/ Alternate Delegate, November 2014 to June 2016; AMA-MSS Region 1 Chair, June 2015 to June 2016; AMA-MSS Reference Committee Member, Annual 2015

4. Sponsor's Narrative Statement
(Describe nominee's accomplishments and contributions using not less than 50, nor more than 250 words.)

It is our honor to nominate Sarah Mae Smith for re-election to the position of Medical Student Trustee on the AMA Board of Trustees.

Few members of our Medical Student Section have worked harder for students than she has during her tenure - first on region leadership, then as Councilor, and now as our student Trustee. When we first met Sarah, she was already carrying a heavy load of responsibilities, yet she made it clear she was always available for questions, open to feedback, and wanting to help students succeed. Over the last three years, she has remained unwaveringly faithful to her commitment to us an advocate, mentor, and friend. We admire her not only for her drive to serve her student colleagues and her patients, but also for her ability to take extremely complex issues and make them approachable. She is always the most prepared person in the room, particularly when she knows she will be the only student and thus representing all our voices in discussions at the highest levels. We believe she will be an even more effective trustee in her second term, not just because of her policy acumen, but because of her passion for the issues and commitment to elevating the voices of medical students within our AMA. We can think of no one we would rather have representing us on

the board and serving as our champion. Thank you for considering Sarah Mae Smith for re-election to the Board of Trustees.

-Halea Meese and Neil Rens

5. Candidate's Statement of Interest
(Not less than 50, nor more than 500 words.)
See attached statement of interest

6. Endorsements
(Are welcome, but not required.)
California Medical Association

Diversity and Demographics

In order to attract the most diverse pool of candidates possible, we request the following self-reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so.**

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

I am a woman, as female physicians continue to be underrepresented in leadership roles within the medical profession and organized medicine, and an aspiring physician-scientist with a strong interest and background in research as an MD/PhD student. I also am from rural upstate New York, and will strive to lift up marginalized voices from other backgrounds.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic?

- ☐ Yes
- ☒ No

What is your self-identified race?

- ☒ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☒ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>

- ☐ Yes
- ☒ No

Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☒ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

9. AMA's Conflict of Interest Policy

Please review carefully the AMA's Conflict of Interest Policy.

All nominees must complete a conflict of interest disclosure form between **October 16-26, 2019**. Upon the AMA's receipt of your nomination submission, an email with details on how to access the disclosure form will be forthcoming. Your nomination materials will not be considered complete until your disclosure form has been completed and returned.

If you are seeking nomination/appointment to a leadership position in another organization, please also review carefully that organization's conflict of interest policy to determine that you will be able to comply. Please also familiarize yourself with the other organization's requirements/instructions for completion of any disclosure form.

If you have questions about the AMA's Conflict of Interest Policy, the AMA's Office of General Counsel (ogc@ama-assn.org) is available to provide guidance.

Please confirm, by signing below, that you have reviewed the AMA's Conflict of Interest Policy and Principles, and understand the guidance provided above.

Paul MacLeod Smith
Signature

10/3/19
Date

SARAH MAE SMITH

Unit 3060, 1801 East Katella Avenue • Anaheim, California 92805 • (518) 496-5895 • ssmith2@hs.uci.edu

EDUCATION

University of California, Irvine School of Medicine — Entered August 2013

MD/ PhD Student, Medical Scientist Training Program

- Letters of Commendation in Clinical Foundations I, Genetics, and Immunology
- Electives: Examine the Painting, Examine the Patient; Global Health; Health Policy; Medical Spanish; Patient Stories, Doctor Stories; Social Medicine; Ultrasound

Johns Hopkins University, Baltimore, Maryland — May 2012

Bachelor of Arts in Neuroscience (Minor in Spanish for the Professions)

- Graduated with General Honors and Departmental Honors in Neuroscience

HEALTHCARE POLICY

American Medical Association and California Medical Association — August 2013 to Present

American Medical Association Board of Trustees, June 2019 to Present

- Represents 50,000 medical student members on the executive body of the largest physician organization in the nation in executing advocacy and implementing the policy created by the House of Delegates
- Determines resource allocation, establishes major legislative and regulatory strategy, performs governance duties, and undertakes high-level strategic vision planning for the association

American Medical Association Council on Medical Service, June 2017 to June 2019

Chair, Committee on Health System Reform, June 2018 to June 2019

- Studied and evaluated the social and economic aspects of medical care and recommends policies on these issues to the AMA House of Delegates related to the socioeconomic factors that influence the practice of medicine
- As Chair of the Committee on Health System Reform, facilitated the Committee's discussions of its reports and presents the Committee's recommendations to the Council
- Served as one of three liaisons to the AMA's Council on Science and Public Health throughout the preparation of the Councils' joint report on aligning clinical and financial incentives for high-value care for the Interim 2018 House of Delegates
- Reports:
    - Council on Medical Service Sunset Review of 2009 AMA House Policies (Council on Medical Service Report 1, Annual 2019)
    - Covering the Uninsured Under the AMA Proposal for Reform (Council on Medical Service Report 2, Annual 2019)
    - Medicare Coverage for Dental Services (Council on Medical Service Report 3, Annual 2019)
    - Reclassification of Complex Rehabilitation Technology (Council on Medical Service Report 4, Annual 2019)
    - The Impact of Pharmacy Benefit Managers on Patients and Physicians (Council on Medical Service Report 5, Annual 2019)
    - Preventive Prostate Cancer Screening (Council on Medical Service Report 6, Annual 2019)
    - Hospital Consolidation (Council on Medical Service Report 7, Annual 2019)
    - Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor (Council on Medical Service Report 8, Annual 2019)
    - Health Plan Payment of Patient Cost-Sharing (Council on Medical Service Report 9, Annual 2019)
    - Alternative Payment Models and Vulnerable Populations (Council on Medical Service Report 10, Annual 2019)
    - Corporate Investors (Council on Medical Service Report 11, Annual 2019)
    - Prescription Drug Importation for Personal Use (Council on Medical Service Report 1, Interim 2018)
    - Air Ambulance Regulations and Payments (Council on Medical Service Report 2, Interim 2018)
    - Sustain Patient-Centered Medical Home Practices (Council on Medical Service Report 3, Interim 2018)
    - The Site-of-Service Differential (Council on Medical Service Report 4, Interim 2018)
    - Aligning Clinical and Financial Incentives for High-Value Care (Joint Report of the Council on Medical Service and the Council on Science and Public Health, Interim 2018)
    - Council on Medical Service Sunset Review of 2008 AMA House Policies (Council on Medical Service Report 1, Annual 2018)
    - Improving Affordability in the Health Insurance Exchanges (Council on Medical Service Report 2, Annual 2018)
    - Ensuring Marketplace Competition and Health Plan Choice (Council on Medical Service Report 3, Annual 2018)
    - Health Plans' Medical Advice (Council on Medical Service Report 4, Annual 2018)
    - Financing of Long-Term Services and Supports (Council on Medical Service Report 5, Annual 2018)
    - Integrating Precision Medicine into Alternative Payment Models (Council on Medical Service Report 6, Annual 2018)
    - Insulin Affordability (Council on Medical Service Report 7, Annual 2018)
    - Addressing the Site-of-Service Differential (Council on Medical Service Report 8, Annual 2018)
    - Coverage for Colorectal Cancer Screening (Joint Report of the Council on Medical Service and the Council on Science and Public Health, Annual 2018)
    - Affordable Care Act Section 1332 Waivers (Council on Medical Service Report 1, Interim 2017)
    - Hospital Surveys and Health Care Disparities (Council on Medical Service Report 2, Interim 2017)
    - Non-Physician Screening Tests (Council on Medical Service Report 3, Interim 2017)
    - Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients (Council on Medical Service Report 4, Interim 2017)
    - Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding (Council on Medical Service Report 5, Interim 2017)
    - Payment and Coverage for Genetic/Genomic Precision Medicine (Joint Report of the Council on Medical Service and the Council on Science and Public Health, Interim 2017)

California Medical Association Council on Medical Services, October 2016 to Present

- Studies and makes recommendations concerning medical service financing and delivery, cost and quality reporting, insurance and reimbursement, managed care, health information technology, and practice management issues
- Student member of the Council that serves as a reference committee for the CMA House of Delegates on related issues
- Reports:
    - Care Delivery and Treatment for the Homeless Population (HOD 2019)
    - Augmented Intelligence (HOD 2019)
    - Addressing Utilization through Improved Care Delivery (HOD 2018)
    - Enhancing Competitiveness of the Healthcare Market (HOD 2018)
    - Reducing Administrative Burdens on Physician Practices (HOD 2018)
    - Addressing Increasing Pharmaceutical Costs (HOD 2018)
    - Health Care Reform: Single-Payer & Public Option (HOD 2017)
    - Health Care Reform: Federal (HOD 2017)

AMA Medical Student Section Delegate, June 2016 to June 2017

- Represented the Medical Student Section in the AMA House of Delegates and chaired the MSS Caucus, leading a team of 54 regional delegates and alternate delegates and several state student delegates
- Transmitted resolutions authored by the Medical Student Section to the House of Delegates, responsible for overseeing the crafting and delivery of testimony in support of the MSS's position on all items of business
- Administered the MSS resolution review process and mentored student resolution authors
- Reports and Resolutions:
    - GC Report A, Biennial Review of Organizations Seated in the AMA-MSS Assembly (Annual 2017)
    - GC Report B, Review of AMA-MSS Statements of Support for HOD Policies (Annual 2017)
    - GC Report C, Updates to the MSS Internal Operating Procedures (Annual 2017)
    - GC Report A, Policy Sunset Report for 2011 AMA-MSS Policies (Interim 2016)
    - GC Resolution 1, Voting Rights of MSS Speaker and Vice Speaker (Interim 2016)

CALPAC Board of Directors, March 2018 to October 2018; January 2015 to December 2015

- Elected to represent medical students on the Board of Directors of the California Medical Association's political action committee
- Participated in interviewing gubernatorial candidates for the 2016 election, culminating in the California Medical Association's endorsement of Gavin Newsom

AMA Medical Student Section House of Delegates Coordinating Committee Chair, July 2015 to June 2016; Member, July 2014 to June 2016

- Acted a policy analyst for the Medical Student Section in determining a well-informed position for the section on AMA House of Delegates resolutions based on MSS policy
- Coordinated the medical student section testimony in the AMA House of Delegates as the head of a reference committee team addressing medical practice, service, and insurance (Reference Committee J) at the 2014 AMA HOD Interim Meeting; headed the reference committee team for public health (Reference Committee D) at the 2015 AMA HOD Annual Meeting

AMA Medical Student Section Region 1 Chair, June 2015 to June 2016

- Oversaw the AMA medical student sections of fifteen states, maintaining communication and collaboration among the constituent students and with other regions, and representing the region to the MSS Governing Council

Region 1 Delegate to the AMA House of Delegates, January 2016 to June 2016

Region 1 Alternate Delegate to the AMA House of Delegates, January 2015 to December 2015

- Elected by medical student representatives from across a region comprised of fifteen states to represent the interests of medical students in the AMA House of Delegates (HOD), participating in the policy-making process and impacting the issues upon which the AMA advocates

California Medical Association Council on Ethical, Legal, and Judicial Affairs, October 2015 to October 2016

- Responsible for studying and making recommendations concerning evolving social and philosophical trends and issues that are of immediate or long-term concern to the medical profession, with emphasis on medical ethics, bio-ethics and attendant areas for the California Medical Association

California Medical Association Reference Committee E (Quality, Ethics, and Medical Practice Issues) Member, October to December 2014

- First medical student in five years to serve on a CMA reference committee
- Deliberated with a team of physicians to offer recommendations on resolutions submitted to the CMA House of Delegates 2014 meeting pertaining to quality, ethics, and medical practice issues, considering online and in-person testimony by physicians and medical students as well as background research

AMA Medical Student Section Reference Committee Member, AMA-MSS Annual 2015

- Worked as part of a team to develop recommendations on resolutions submitted to the AMA-MSS assembly for Annual 2015 based on online peer testimony and background research

AMA-MSS Region 1 Secretary, June 2014 to June 2015

- Served as Region 1's Secretary, coordinating communication and organization among the region's delegations while also working on projects with the Region 1 Governing Council
- Instituted regional resolution committees to review resolutions considered at the MSS assembly at Annual 2015, to enable the region to have a well-informed position on each resolution

AMA-MSS Region 1 Meeting Co-Chair, February 6th to 8th, 2015

- Planned a meeting attended by over eighty medical students from five states centered around "Engagement in the Changing Landscape of Healthcare Policy"

California Medical Association Council on Legislation, February 2014 to December 2014

- Served as the medical student on the California Medical Association Council on Legislation, including an in-person meeting in March 2014 to set the organization's legislative agenda for the year, providing the students' perspective on the bills reviewed by the assembly

UC Irvine Delegate to American Medical Association- Medical Student Section and California Medical Association, October 2013 to January 2015

- Responsible for official representation of UC Irvine to the Orange County Medical Association, California Medical Association, and American Medical Association
- Attended CMA Legislative Advocacy Day in 2014 and 2015; met with California state legislators to advocate for increased graduate medical education funding, removal of the personal belief exemption for vaccination, and increased Medi-Cal reimbursements
- Lobbied at the California Democratic Party Convention in March 2014 under the auspices of the CMA to advocate against an anti-MICRA ballot measure that would increase healthcare costs and decrease access to care; returned to the CDP Convention in April 2015 to advocate for removal the personal belief exemption for vaccination
- Author of twenty-seven AMA-MSS resolutions passed at A-14, I-14, A-15, I-15, A-16, I-17, A-18, and I-18:
    - Oppose Requirements of Hormonal Treatments for Athletes (I-18)
    - Opposing Office of Refugee Resettlement's Use of Medical/ Psychiatric Records for Evidence in Immigration Court (I-18)
    - Compassionate Release for Incarcerated Patients (I-18)
    - Removing Sex Designation from the Birth Certificate (I-18; not considered)
    - Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents (I-18)
    - Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings (A-18)
    - Support of Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research (A-18)
    - Medical Student Involvement and Validation of the Standardized Video Interview Implementation (I-17)
    - Opposition to Measures that Criminalize Homelessness (I-17)
    - Requiring Blinded Review of Medical Student Performance (I-17; referred)
    - Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers (A-16)
    - Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States' Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability (A-16)
    - Eliminating "Fail First" Policy in Addiction Treatment (A-16)
    - Opposing Tax Deductions for Direct to Consumer Advertising (A-16)
    - Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (A-16)
    - Hospital Workplace and Patient Safety and Weapons: Do No Harm – Medicine, Not Bullets (A-16)
    - Addressing the U.S. Drug Shortage Crisis (I-15)
    - Addressing Communication Deficits in Medical School Curricula (I-15)
    - Increasing Availability and Coverage for Immediate Postpartum LARC Placement (I-15)
    - Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities (I-15)
    - Supporting Autonomy for Patients with Differences of Sex Development (I-15)
    - Targeted Education to Increase Organ Donation (I-15)
    - Ensuring High Quality Care for All Veterans and Their Families (I-15)
    - Drug Pricing Reform (I-15)
    - Improving the Intersection between Law Enforcement and the Mentally Ill (A-15)
    - FDA Clinical Trial Misconduct Reporting and Transparency (A-15; reaffirmation in lieu of)
    - Removal of Cannabis Use as a Relative Contraindication for Potential Organ Transplant Recipients (I-14)
    - Recognition of the True Health Status and Risks for Refugees from Central America (I-14; not considered)
    - Eradicating Homelessness (A-14)
    - Incorporating Community Health Workers into the U.S. Health Care System (A-14)
    - Patient Confidentiality in National Security Investigations (A-14)
- Original author of nineteen MSS resolutions introduced to the AMA House of Delegates:
    - Oppose Requirements of Hormonal Treatments for Athletes (A-19; referred for study)
    - Opposing Office of Refugee Resettlement's Use of Medical/ Psychiatric Records for Evidence in Immigration Court (A-19; adopted as amended)
    - Compassionate Release for Incarcerated Patients (A-19; referred for study)
    - Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents (A-19; adopted as amended)
    - Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings (I-18; adopted as amended)
    - Opposition to Measures that Criminalize Homelessness (A-18; referred)
    - Medical Student Involvement and Validation of the Standardized Video Interview Implementation (I-17; adopted as amended)
    - Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers (I-16; adopted as amended)
    - Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States' Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability (I-16; referred for study)
    - Eliminating "Fail First" Policy in Addiction Treatment (I-16; adopted as amended)
    - Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (I-16; adopted as amended)
    - Opposing Tax Deductions for Direct to Consumer Advertising (A-16; referred for study)
    - Addressing the U.S. Drug Shortage Crisis (A-16; referred for decision)
    - Increasing Availability and Coverage for Immediate Postpartum LARC Placement (A-16; adopted as amended)
    - Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities (A-16; adopted as amended)
    - Supporting Autonomy for Patients with Differences of Sex Development (A-16; referred for study)
    - Targeted Education to Increase Organ Donation (A-16; adopted)
    - Eradicating Homelessness (A-15; adopted as amended)
    - Incorporating Community Health Workers into the U.S. Health Care System (1-14; referred for study)

- Author of eleven CMA resolutions adopted:
  - Mental Health Disclosures On Physician Licensing Applications (2019)
  - Repeal Anti-Camping Ordinances to Protect the Health of Homeless Individuals (2019)
  - Supporting Autonomy for Patients with Differences of Sex Development (2018)
  - Funding and Expanding the University of California Program in Medical Education (UC PRIME) (2018; reaffirmed in lieu of)
  - Medically Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis (2017)
  - Opposing Tax Deductions for Direct-to-Consumer Advertising (2016)
  - Promoting Usage of LGBTQIA Inclusive Language in Medical Documentation (2016)
  - Advocacy for Voluntary News Media Standards on Coverage of Mass Shooting (2016)
  - Housing First To Eradicate Homelessness (2015)
  - Medi-Cal Coverage for Immunosuppressive Therapy for Organ Transplant Recipients (2015)
  - Senior Sexual Activity and STI Prevention (2015)
  - Remove Cannabis Use as a Relative Contraindication for Transplant Recipiency (2014)

COMMUNITY SERVICE, LEADERSHIP, AND ACTIVITIES

UC Irvine Medical Initiative Against Homelessness — August 2013 to June 2016
President, January 2014 to June 2015
- Actively involved in the Recuperative Care and Health Education Outreach programs, offering healthcare for members of the homeless community in Orange County and promoting healthy practices through education for homeless individuals

UC Irvine School of Medicine Oncology Interest Group — September 2013 to Present
President, February 2014 to June 2015; Continuing Participant
- Planned and coordinated numerous talks for medical students from physicians spanning the field of oncology, including a pediatric oncologist, a panel of oncology fellows and residents in various specialties, and a professor of medicine who was a cancer patient

UC Irvine School of Medicine Neurosurgery Interest Group — March 2014 to Present
Vice-President, March 2014 to June 2015; Continuing Participant
- Created a new interest group at UC Irvine to support medical students interested in pursuing careers in neurosurgery
- Coordinated the first annual Conference on Neurosurgical Anatomy on May 23, 2014 to expose students to neuroanatomy relevant to neurosurgical procedures and the neurosurgical field

UC Irvine School of Medicine Flying Samaritans — August 2013 to Present
Trip Coordinator, December 2013 to December 2014; Continuing Volunteer
- Organized a group of medical students and Orange County physicians to travel to Valle Redondo, Mexico each month to provide free treatment to the surrounding community with an emphasis on lifestyle changes and counseling
- Participated in the healthcare delivery by taking vital signs, collecting patient histories, and presenting to the attending physicians

UC Irvine School of Medicine Academic Medicine Interest Group Journal Club Moderator — February 2014 to February 2015
- Moderator of monthly presentations and discussions of academic medical literature, hosted by a new interest group

UC Irvine Outreach Clinic — September 2013 to Present
Director of Referrals and Community Relations, December 2013 to January 2015; Continuing Volunteer
- Acted as the liaison and works to establish strong relationships with community organizations and medical specialists to provide free comprehensive healthcare to the underserved and uninsured population of Orange County at the Lestonnac Clinic

2014 International Emory Global Health Case Competition Member — January 2014 to March 2014
- Chosen to represent UC Irvine at this international competition as one of two medical student members of the six-person team
- Developed a viable solution (the institution of a Civil Society Advisory Board) in response to a case prompt asking participants to re-imagine the World Health Organization)
- WHO recently proposed a new framework of engagement with non-state actors which follows closely with our proposed solution

RESEARCH EXPERIENCE

PhD Dissertation Work, Laboratory of Dr. Charles Limoli — March 2016 to Present
University of California, Irvine, Department of Radiation Oncology
- Exploring the cognitive effects of temozolomide, an alkylating chemotherapeutic agent, and fractionated irradiation
- Investigating the therapeutic effects of different cell types, including embryonic stem cells and induced pluripotent stem cells, and their associated exosomes on combined irradiation/chemotherapy-induced cognitive dysfunction

PhD Rotation in the Laboratory of Dr. Robert Hunt — January 2016 to March 2016
University of California, Irvine, Department of Anatomy and Neurobiology
- Examined the role of CHD2, a chromatin remodeler, in epileptic encephalopathies by characterizing its expression in the brain during development and the anatomy of cells in the brain in CHD2 knockout

PhD Rotation in the Laboratory of Dr. Charles Limoli — September 2015 to December 2015
University of California, Irvine, Department of Radiation Oncology
- Investigated stem cell therapies for radiation-included cognitive dysfunction

PhD Rotation in the Laboratory of Dr. Yongsheng Shi — June 2014 to August 2014
University of California, Irvine, Department of Microbiology and Molecular Genetics
- Studied post-transcriptional gene regulation in stem cells and cancer, specifically the interaction between CstF50, a polyadenylation factor, and p53, the most commonly mutated tumor suppressor in cancer, using techniques such as cell culture, protein gel electrophoresis, Western blotting, and immunopurification

Laboratory of Dr. Xiaoqin Wang, Johns Hopkins University, Department of Biomedical Engineering — January 2010 to May 2013
- Investigated vocal-auditory interactions in marmoset monkeys using behavioral experiments and computational analysis

Laboratory of Dr. Paul Worley, Johns Hopkins University, Department of Neuroscience — October 2009 to April 2012
- Examined the role of immediate early genes in learning and memory in mouse models

Acknowledgment of Time Commitment and Confirmation of Good Standing

Please acknowledge that you have discussed the time commitment for this position and made appropriate arrangements with your dean or clinical preceptor by signing below. The signature of your Dean or Advisor is required (1) to acknowledge the time commitment involved in a Board of Trustees position and (2) to verify that you are a student in good-standing with your medical school.

Candidate Signature: Sarah Mae Smith

Medical School Dean or Advisor Signature: MD

CALIFORNIA MEDICAL ASSOCIATION

Thursday, October 3rd, 2019

Dear Members of the American Medical Association Medical Student Section,

I write to enthusiastically recommend Sarah Smith for re-election the Medical Student seat on the Board of Trustees. Over the past several years, Sarah has made a lasting impression on our California delegation and physician leaders through her work on policy development and grassroots advocacy. The profession would be greatly served by her re-appointment to the AMA Board of Trustees.

Sarah's leadership, organizational skills, analytical abilities and familiarity with the issues of the day were first lent to CMA in the fall of 2013 as an active participant at the CMA House of Delegates meeting. She quickly developed a reputation as a thoughtful contributor to the policy-making process, always very well prepared and researched on the variety of healthcare subjects discussed at these meetings.

Her experience with our House of Delegates meeting only fueled her passion for health care policy and prompted her election by her peers to serve on CMA's Council on Legislation. As a member of this Council, Sarah helped establish CMA positions on state legislation in California, the most active and forward-thinking state on health care policy. Sarah, through her advocacy on the council, ensured the voices of the medical students were fully represented. Her excellent work on the council was widely recognized by CMA leadership and staff, eventually leading to yet another promotion.

Sarah was the first medical student in many years to serve on a CMA House of Delegates Reference Committee. As a member of the Quality, Ethics, and Medical Practice Issues Reference Committee, Sarah joined other physicians in examining difficult, complex issues that went to the core of the profession. Continuing her streak of excellence, Sarah then served on the CMA's Council on Ethical, Judicial, and Legal Affairs, and was at the forefront of CMA's discussion to change its position on physician-aid-in-dying. In October 2016, Sarah was appointed to the CMA's Council on Medical Services and was involved in developing CMA's policy on federal health care reform and potential universal health care financing and delivery systems.

Sarah performed every one of these roles with exceptional professionalism, thoughtfulness, and the maturity of a seasoned health policy expert, resulting in her re-appointment to the CMA's Council on Medical Services for 2018 and 2019. On the Council on Medical Services, she has engaged heavily in the development of the Council's major issues reports on Addressing the Competitiveness of the Healthcare Market, Addressing Increasing Pharmaceutical Costs, and Homelessness, dedicating herself to developing evidence-based recommendations to

better care for our patients. And if her service to CMA is not impressive enough, she also held numerous positions within the AMA-MSS, including Region 1 Delegate, Region 1 Chair, House of Delegates Coordinating Committee Chair, and Medical Student Section Delegate on the Governing Council, to name a few. Most recently, she served as the medical student on the AMA Council on Medical Service from 2017 to 2019, quickly establishing herself as a trusted and analytical member of the Council in chairing the Council's Committee on Health System Reform in her second year on the Council.

While Sarah's contributions to the AMA's and CMA's policy-making process are substantial, her résumé on grassroots advocacy is almost unmatched. Sarah was one of our first students to sign up for CMA's effort against Proposition 46, a special interest-funded initiative that would have increased health care costs while decreasing access to care. Sarah helped organize and then joined dozens of medical students to attend the California Democratic Party Convention meeting to educate California Democratic delegates and legislators about the dangers of the initiative and to urge its rejection, which voters overwhelming did at the ballot box later that year.

Just a few months later, Sarah was once again part of a group of medical students at the California Democratic Party Convention, but this time to educate convention attendees about the need to support legislation to eliminate the personal belief exemption for childhood vaccinations. In this effort, Sarah braved hundreds of misinformed protestors and a multitude of personal threats in order to explain the science and efficacy behind vaccines. Her calm and analytic approach to this subject gave many Democratic delegates the assurances needed to support our efforts.

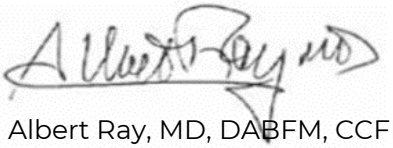
And finally, in 2016, Sarah and her colleagues at UC Irvine devoted a significant amount of their free time to collect signatures for CMA's effort to qualify a tobacco tax ballot initiative. When our campaign was reporting that we were in danger of not collecting enough signatures to qualify for the ballot, Sarah put the word out to her medical student colleagues, quite literally a living organism of its own, that we needed help. As one might imagine, approaching strangers to sign a ballot petition is not for the faint of heart, but Sarah and her fellow students did not hesitate when the call for help was made. With their help, CMA was able to put that tobacco tax on the ballot and get it overwhelmingly passed by the California electorate.

Further, Sarah is the consummate team player and has served as an integral member of the California Delegation to the AMA, as well as its geographic caucus, the PacWest Conference. When she served as a California Delegate to the AMA, she expertly organized an electronic platform to record the PacWest Conference's positions on items of business to better coordinate the caucus's discussions and helped to institutionalize this process for years to come. She has long been a trusted source of counsel for the physician leaders of the California Delegation, working to better integrate medical students into the delegation and serving as a tenacious advocate for the policy priorities of medical students. Sarah has also been a valued member of the California contingent at the AMA's National Advocacy Conference since 2017, joining our physician advocates for visits on Capitol Hill to promote

issues from increased funding for graduate medical education to protections for health professionals with DACA status to surprise billing fixes.

Over the course of these achievements, many physician leaders have remarked to me about the exceptional crop of medical student leaders in California. Sarah leads the future of medicine with her passion, perseverance, and outstanding work quality. It is because of students such as Sarah, with her exceptional drive and leadership abilities, that the future of the profession is alive and brighter than ever. I wholeheartedly recommend her for re-election to the AMA Board of Trustees.

Sincerely,



Albert Ray, MD, DABFM, CCFP, FAAFP, FCFP, CPC
Chair, California Medical Association Delegation to the AMA

UCI University of California, Irvine

October 2, 2019

Re: Sarah Mae Smith

American Medical Association
Medical Student Section

To the American Medical Association Medical Student Section:

I write to express my enthusiastic support of Sarah Mae Smith's election to the AMA Board of Trustees. Sarah is an MD/PhD student in the Medical Scientist Training Program at the University of California (UCI), Irvine School of Medicine. She is pursuing an Environmental Health Science doctoral program in the laboratory of Dr. Charles Limoli.

Sarah has served on the American Medical Association's Board of Trustees for the past year, which she describes as one of the most defining experiences of her medical school career. She believes deeply in the power of physician advocacy to forward the interest of patients. She has been involved in the AMA since her first year, serving as UC Irvine's delegate to the AMA Student Section as an MS1 and subsequently as a Delegate in the AMA House of Delegates, Chair of Region 1 in the AMA Medical Student Section, and Chair of the AMA-MSS House of Delegates Coordinating Committee. She has been involved in the California Medical Association Council on Medical Services, Council on Ethical, Legal, and Judicial Affairs, and Council on Legislation.

At UCI, she has been a tireless advocate, serving as the president of the Medical Initiative Against Homelessness (MIAH), the trip coordinator for the UC Irvine Flying Samaritans chapter, and the director for referrals and community relations for the UC Irvine Outreach Clinic. Sarah's leadership, drive, and enthusiasm make her an ideal candidate for the AMA Board of Trustees. I hope that she can continue build on all of the important work she has been a part of in this position.

I know that Sarah will work diligently to further the vision and goals for the AMA. I give her my full support and hope you will too.

Sincerely,



Megan Boysen Osborn, MD, MHPE
Associate Dean for Students
UC Irvine School of Medicine
AMA Member
mbo@uci.edu

UCI School of Medicine
1001 Health Sciences Road
Irvine, CA 92697

som.uci.edu



Re-Elect
Sarah Mae Smith
AMA Board of Trustees

MEMORANDUM

TO: JESSE M. EHRENFELD, MD, MPH, CHAIR, BOARD OF TRUSTEES

FROM: SARAH MAE SMITH, MEDICAL STUDENT SECTION

SUBJECT: MITIGATING THE EFFECTS OF HOSPITAL CLOSURES ON PHYSICIANS-IN-TRAINING AND PATIENTS

Dear Dr. Ehrenfeld,

On behalf of the Medical Student Section of the American Medical Association, I write to urge the Board of Trustees to take decisive action to mitigate the effects of hospital closures on physicians-in-training and the patients whose care is disrupted by such closures. The perils of abrupt and unexpected hospital closures were brought into sharp contrast earlier this year with the announcement in June that Hahnemann University Hospital would be filing for Chapter 11 bankruptcy and permanently closing.[1] When this occurred, the Medical Student Section was gratified to see the AMA immediately intercede to support the 571 residents and fellows whose career paths were thrown into disarray by this decision. However, despite the best efforts of the AMA, the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and other supportive stakeholders, the affected residents and fellows still experienced untenable stress and uncertainty, and it remains unclear how the healthcare needs of low-income and vulnerable patients previously served by the 496-bed facility will be met.[2-4] In recognition that the rate of hospital closures is increasing precipitously[5] and thus similar developments are almost inevitable in the future, we ask that the AMA aggressively advocate for the establishment of procedures and practices that provide protection, assurances, and stability for physicians-in-training thrust into analogous circumstances, as well as policies that seek to deter the closures of safety-net hospitals and address the impact of increasing influence of private equity within the health system.

The closure of the storied Hahnemann University Hospital, which was founded in 1848 and had employed over 2,500 workers, constituted the largest displacement of medical residents by a single event in history.[6-9] The fifty-nine international residents training with J-1 visas were placed in a particularly sensitive situation, as their visas were contingent on employment at the hospital and they were under threat of being obligated to leave the United States if they were unable to identify an alternative position with another graduate medical education training program within thirty days.[1,8] Even among U.S. citizen residents and fellows, the days following the announced closure were filled with confusion and unpredictability, amid a cease-and-desist order from The Pennsylvania Department of Health directing the hospital not to take any action towards closing down and assertions that an agreement had been reached to transfer the majority of Hahnemann's graduate medical education programs to Tower Health.[10-12] Understanding the precarious circumstances facing physicians-in-training at Hahnemann, the AMA swiftly intervened on their behalf, collaborating with the AAMC, the ACGME, and the Educational Commission for Foreign Medical Graduates (ECFMG) to advocate for sustainable funding for their graduate medical education and offer guidance and resources.[1,8,9,13-15] The AMA urged Centers for Medicare & Medicaid Services Administrator Seema Verma to waive rules and regulations creating barriers for the impacted residents and fellows to transition to other

GME programs, including the "return home" or physical presence requirement that residents be physically present at Hahnemann on the day the hospital closes in order for the federal funding associated with their GME slots to be transferred to their "receiving" programs.[9] The AMA also asked that CMS consider making federal GME funding available to residents completing transitional years at other institutions who had matched at Hahnemann to begin their advanced residency training in July 2020 and re-categorizing these residents as "displaced", and pressed the U.S. Department of State, the United States Citizenship and Immigration Services (USCIS), and the ECFMG to allow for extensions to the 30-day grace period requirement for residents holding J-1 visas.[8-9] Much of this advocacy was successful- more than 1,300 training positions were identified for displaced residents,[14] the vast majority of whom were able to transfer to new training programs,[16] and all fifty-nine residents with J-1 visas found new graduate medical education slots without facing deportation.[17] The AMA also committed $50,000, with the AMA Foundation committing an additional $20,000, to the Hahnemann University Displaced Resident Fund, orchestrated through the Philadelphia County Medical Society to provide financial assistance for relocation expenses for affected residents and fellows.[16,18]

Despite the relative success of the AMA's efforts in conjunction with other stakeholders to support physicians-in-training impacted by the incident around the Hahnemann closure, much work remains to be done in this realm. For one, although almost all of the Hahnemann residents and fellows were ultimately able to transition to new GME programs, the uncertainty and confusion in the initial days following the announcement created unnecessary stress and anxiety for those involved.[19] In the aftermath of this occurrence, it is critical that the AMA come together with the AAMC, ACGME, ECFMG, and other interested parties to conduct a post-mortem analysis of how the situation was handled, and develop best practices for future closures of teaching hospitals. Many of the overly-stringent CMS requirements around the reallocation of federal GME funding to the "receiving" programs and the brief grace period for J-1 visa holders were either able to be waived or otherwise nonfactors in the end, but it would be preferable if standard exceptions were created around similar circumstances in the future, which would help alleviate the immediate alarm and consternation experienced by physicians-in-training at such hospitals, and other potential issues were proactively addressed before they arise. It is also important to note that not all residents affected by the closure have had positive outcomes- in spite of the AMA's advocacy to the contrary, interns completing a transitional year residency at an outside institution from 2019-2020 who had matched at Hahnemann to begin their advanced residency training in July 2020 (residents training in fields such as ophthalmology, anesthesiology, diagnostic radiology, and neurology) were not released with federal GME funding, and were instead forced to re-enter the Match or identify a training slot outside of the Match without the benefit of bringing along their own funding.[13] This decision has placed significant unwarranted stress on the residents in these specialties, and the AMA should work to ensure that in the future, all residents who have matched into GME programs and begun their training are released with their associated direct graduate medical education funding and indirect medical education funding, to better and more equitably facilitate their transfer to new training programs.

Although developing standard practices around training hospital closures is necessary given the likelihood of similar occurrences in the future, as in medicine, the ideal outcome is actually prevention- which makes advocating for policies that reduce the probability of future hospital closures a high priority as well. This is also the best objective for the low-income and vulnerable patient populations served by safety-net hospitals like Hahnemann, who may face significant difficulties identifying an alternative source of care in the wake of such closures. Addressing this issue is especially important in light of analyses

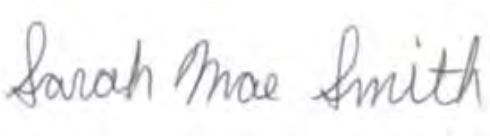
suggesting that hospital closures are increasing in frequency, with rural hospitals disproportionately impacted.[5] Though this was not a factor in the Hahnemann closure, one intervention that is known to improve the financial stability of hospitals is the expansion of Medicaid under the Affordable Care Act. Numerous studies have borne out this finding; a 2016 analysis found dramatic decreases in uninsured hospital stays and increases in Medicaid-insured hospital stays in states that had expanded Medicaid, while changes in Medicaid and uninsured discharges in states that had not expanded Medicaid were small and statistically insignificant.[20] Another study found that the Medicaid expansion associated with the ACA significantly decreased provision of uncompensated care by hospitals (including relative to states that did not accept the expansion) and identified that this effect was especially acute for disproportionate share hospitals responsible for the provision of care to a significant number of low-income patients, which one might expect might be at greatest risk of closure.[21] There is evidence that rural hospitals in states that did not expand Medicaid provide greater amounts of uncompensated care as a percentage of revenues and higher dollar values of unrecoverable debt and charity care, contributing to greater financial vulnerability as compared to rural hospitals in Medicaid expansion states, and rural critical access hospitals in non-expansion states have significantly lower operating margins than those in expansion states.[22] The link between expansion of Medicaid and hospital closures has even been explicitly studied, with a 2018 paper published in *Health Affairs* finding that the ACA's Medicaid expansion was associated with improved hospital financial performance and substantially lower rates of hospital closures, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion.[23] The AMA has long been a strong advocate for Medicaid expansion,[24] but this should serve as a reminder of the imperative to redouble our efforts to encourage the fourteen states that have not yet adopted the Medicaid expansion to do so.[25]

Finally, it is difficult to ignore the potential impact of private equity involvement on the closure of Hahnemann University Hospital. In January 2018, Hahnemann was sold to the American Academic Health System, an affiliate of the private equity firm Paladin Healthcare; less than two years later, the hospital filed for Chapter 11 bankruptcy, but the entity that owns the land on which the hospital is located is not included in the filing, separated out from the hospital itself during the purchase.[3,19,26] The value of the land is significant given its central location near City Hall and the convention center, fueling speculation that the investor who purchased Hahnemann in 2018 intentionally allowed it to fail financially in order to repurpose the land for more lucrative objectives.[19,26] As a member of the AMA Council on Medical Service, I worked on the Annual 2019 report that considered the impact of corporate investors on the health system;[27] as the involvement of such investors continues to intensify, we need to evaluate additional recommendations to ensure that negative implications for medical education and access to care do not manifest. One step the AMA should take to blunt the impact is to join the Centers for Medicare and Medicaid Services, the AAMC, and the ECFMG in opposing the proposed sale of Hahnemann's residency program assets for $55 million to Tower Health- particularly given the shortage of GME funding, residency slots should not be "assets" to be bought and sold by corporate entities.[28-29] Instead, as argued by lawyers for the Justice Department, residency slots should be allocated by HHS based on workforce needs and strength of medical education opportunities for residents and fellows.

Our AMA served as a powerful ally to the residents and fellows training at Hahnemann University Hospital in the aftermath of its closure, and I am proud of the actions taken by our Board to facilitate smooth transitions for these physicians-in-training to their new GME programs. However, with that situation largely stabilized, it is time to look forward and

develop more streamlined practices and protections for residents and fellows experiencing similar closures in the future, advocate for policies such as the expansion of Medicaid to increase the probability that we are able to prevent the closures of safety-net and teaching hospitals, and mitigate the potential for negative impacts of private equity on the graduate medical education system. Thank you for your consideration, and for the AMA's leadership on this issue.

Yours Truly,



Sarah Mae Smith

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6. NBC10 Staff. Hahnemann University Hospital to Close, Leaving Thousands Out of Work. *NBC10 Philadelphia*. June 26, 2019. https://www.nbcphiladelphia.com/news/local/Hahnemann-Hospital-Closing-511831882.html.

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8. Madara JL. Letter to G. Kevin Saba, Acting Deputy Assistant Secretary for Private Sector Exchange Designation, U.S. Department of State; Ken Cuccinelli, Acting Director, Department of Homeland Security, U.S. Citizenship and Immigration Services; and William W. Pinsky, MD, President and Chief Executive Officer, Educational Commission for Foreign Medical Graduates. American Medical Association. July 25, 2019.

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Re-Elect
Sarah Mae Smith
AMA Board of Trustees



@SarahMaeSmith33

ssmith2@hs.uci.edu
Sarah.Mae.Smith@ama-assn.org

(518) 496-5895

My name is Sarah Mae Smith, and I am asking you to re-elect me to the American Medical Association's Board of Trustees because I have a track record of experience that I am successfully putting to work for the Medical Student Section. Over the past six years, I have found a home in the AMA and the MSS, advocating for policies that advance health equity and improve the health system for our patients. This year, I have been fighting to put these policies into practice and elevate our MSS priorities on the Board of Trustees. My institutional knowledge, diligent preparation, and extensive experience representing the MSS throughout the organization have served me well in spurring action on issues that matter to us, and I have fostered relationships with Board members and senior management that would enable me to expand my impact in a second term. I look forward to employing this skillset to continue championing patient-centered values and addressing our needs as physicians-in-training with a steady hand during a tumultuous era of fast-paced change in health policy.

TACKLING THE NATION'S PUBLIC HEALTH EPIDEMICS

Working with other young AMA leaders to bring the House of Delegates together in the wake of the Pulse nightclub shooting to declare gun violence a public health crisis at Annual 2016 was one of the most consequential endeavors of my time in organized medicine. I have carried that experience forward and am proud of our continued advocacy in this space (#ThisIsOurLane), elevating the imperative for federal funding for gun violence research by the Centers for Disease Control and Prevention and universal background checks on all gun sales. I'm also passionate about supporting our AMA's efforts to end the scourge of opioid addiction, including by facilitating access to medication-assisted treatment, and to reduce maternal mortality and mortality (especially the disproportionate impacts on minority women) through advocacy for maternal mortality review committees and extending coverage under Medicaid, CHIP, and WIC for post-partum women. Further, I have worked to advance our efforts to proactively respond to the epidemic of electronic cigarette utilization by young people. As an MD/PhD student, I pledge to center the science in promoting evidence-based solutions to these and other public health crises.

PROTECTING THE FUTURE OF MEDICINE

When the closure of Hahnemann University Hospital was announced in late June, I was a staunch proponent for defending opportunities for the affected physicians-in-training, which was borne out in our AMA's advocacy urging increased assistance, guidance, and flexibility for affected residents and fellows seeking new positions in training programs, as well as the establishment of the Hahnemann University Displaced Resident Fund offering grants to alleviate relocation costs. This closure serves as a reminder of the urgency of preserving and enhancing stable funding for graduate medical education, particularly in light of the impending physician shortage, as well as enshrining other protections for physicians-in-training such as the assurance that we can finish our training as well as continue to serve those most in need. The Medical Student Section has also consistently stood at the vanguard of innovation and technology in healthcare, and I have engaged in leading these efforts within organized medicine, from guiding the progress of the AMA's health incubator Health2047 to developing policy around augmented intelligence in healthcare on the California Medical Association's Council on Medical Services.

IMPROVING SOCIAL DETERMINANTS OF HEALTH

I have been engrossed in improving the socioeconomic factors that cause significant morbidity and mortality for our patients through the machinations of the AMA since I was an MS1, writing resolutions to advocate for housing-first approaches to address chronic homelessness and support the incorporation of community health workers into the U.S. healthcare system. This year on the Board, I have been making the case that addressing social determinants of health is integral to fulfilling the AMA's strategic arcs.

DEDICATED ◊ PASSIONATE ◊ KNOWLEDGABLE ◊ EXPERIENCED







This includes Professional Satisfaction and Practice Sustainability, recognizing that physicians cannot effectively take care of their patients if there are factors outside of the exam room that negatively impact their health (fueling dissatisfaction), and Improving Health Outcomes, with the National Academy of Medicine noting that medical care is only responsible for 10-20% of modifiable contributors to better health. This is reflected in our tenacious advocacy for protections from employment discrimination for LGBTQ people under Title VII and preserving eligibility for the Supplemental Nutrition Assistance Program in the past few months, and I am committed to continuing to push our organization to take a more expansive view of what is encompassed within health.

MITIGATING HEALTH DISPARITIES

It is unacceptable that patients of different races, ethnicities, nations of origin, sexes, sexual orientations, and gender identities continue to face divergent health outcomes in the United States, and we must take tangible action to pursue health equity and justice. I have been a steadfast leader in the AMA's work protecting the health of our nation's immigrants, from calling attention to the abhorrent conditions in immigrant detention centers and urging the administration to adopt humanitarian standards in these facilities, to decrying the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent (pursuant to the adoption of an MSS-introduced resolution!), to opposing U.S. Citizenship and Immigration Serivces's decision to revoke its acceptance and adjudication of medical deferrals from deportation for children and families receiving life-saving treatment in the United States, which was successfully reversed thanks in part due to our persuasive . I have also worked with our Board to combat challenges to the Title X program through litigation and legislative advocacy, to ensure our low-income patients have access to family planning and preventive health services, and my background on the AMA Council on Medical Service has enabled me to meaningfully contribute to our efforts advancing proposals to expand insurance coverage and affordability, and opposing initiatives and litigation that would undo the coverage gains following the Affordable Care Act. With millions still uninsured and underinsured, however, our work is far from over. I will persist in amplifying the voices of underserved and disadvantaged populations on the Board.

WHO I AM AND WHY I AM RUNNING FOR RE-ELECTION

I am running for re-election as your Trustee because I believe it is important for medical students and our generation of physicians to have a strong voice at the upper echelons of AMA leadership, someone who cares profoundly about AMA policy and the future of healthcare, understands all facets of our section, and can advocate to ensure that the AMA centers our priorities on the values of our Medical Student Section. The Board of Trustees plays a pivotal role in turning policy into action, and enacting the will of the House of Medicine. In this realm, we determine resource allocation within the Association, establish major legislative and regulatory strategy, perform governance duties, and undertake high-level strategic vision planning. With all of these objectives, a successful MSS Board member needs to excel in relationship-building and teamwork, as well as possess a policy prowess and a deep understanding of the organization; there is no substitute for experience.

I have a proven record of effectiveness in my undertakings within the AMA, having served in a multitude of roles spanning from standing committee and region leadership to the MSS Governing Council to the Council on Medical Service and now the Board. I have learned an immense amount from each of these experiences and have a sense of the challenges and frustrations of these positions, but also the potential of our medical student leadership, which facilitates problem-solving and ensuring our section has the resources it needs to succeed. I strive to be the most prepared person in the room, which is important as the youngest member of the Board where any misstep is magnified, and I have cultivated my aptitude for listening, learning, and building collaborations within the boardroom. My institutional memory has been critical in my tenure thus far, especially with significant turnover among section staff. I look forward to building on the foundation we are creating and the relationships I am establishing to expand the capability of the MSS, and in particular improving our means of communication to our members.

I have been immensely honored and humbled to serve as your MSS Trustee this year, and I ask for your vote to continue furthering the progress we have made. I look forward to seeing you in San Diego!

DEDICATED ◊ PASSIONATE ◊ KNOWLEDGABLE ◊ EXPERIENCED

Medical Student Section Governing Council Application – Interim 2019 (Chair-Elect)

ALL APPLICATION MATERIALS MUST BE RECEIVED BY October 4, 2019 at 11:59pm Central Time

Note: You must be a current AMA member to apply.

AMA Medical Student Section (MSS) Governing Council members are expected to attend up to four Council meetings per year, lead the AMA National Medical Student Meetings (Annual and Interim) and the Medical Student Advocacy and Region Conference, and participate in conference calls as scheduled. Comprehensive review of agenda materials, punctual attendance of all in-person and virtual meetings, and regular communication is required. Due to the time commitment involved with these positions, applicants must obtain their Dean's signature of approval.
Total term of service for Governing Council officers is one year, commencing after the Annual Meeting. **The Chair-elect/ Chair/ Immediate Past Chair term is two years, commencing after the Interim Meeting.**

The elected AMA Medical Student Section (MSS) Governing Council member should be available to attend the AMA MSS Governing Council Orientation, the AMA Medical Student Section Interim and Annual Meetings, and the AMA Medical Student Advocacy and Region Conference.
The 2020 Interim meeting is held November 14-17 in San Diego, CA and requires at least a 4-day time commitment (Thursday – Sunday). The 2020 Annual meeting is held June 6-10 in Chicago, IL and requires at least a 4-day commitment. The positions of Chair, Delegate, and Alternate Delegate are required to remain for the AMA House of Delegates meeting which entails an additional 2 days at Interim and 3 days at Annual. The 2020 AMA Medical Student Advocacy and Region Conference is a 3-day meeting held March 5-7 in Washington, D.C.
Governing Council Meetings are held in conjunction with these three main meetings plus a stand-alone orientation for 2 days in late June or early July.
Please acknowledge that you have discussed this time commitment and made appropriate arrangements with your Dean or Clinical Preceptor by signing below. The signature of your Dean or Advisor is required to acknowledge the time commitment involved in a Governing Council position and to verify that you are a student in good-standing with your medical school.
Click here to download the PDF for signature

Two letters of endorsement will be allowed in the Election Manual: one optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in, and one optional letter of endorsement by staff of the state society from the state the candidate attends medical school. No other letters of endorsement may be included in the Election Manual.

***Expected Graduation Date:**

Month **Day** **Year**

May 21 2021

Enter a date between 01-01-2010 and 12-31-2030.

*Governing Council position:

Chair-Elect

***Click here to acknowledge your attendance commitment:**

- ☒ I acknowledge my commitment

All application materials should be uploaded below for inclusion in the Election Manual. If signatures are not included on the uploaded documents, please have your Letters of Endorsement and Dean's signature sent to: mss@ama-assn.org

Supporting Information

Please submit the following items as one attachment.

1. **Current Curriculum Vitae which includes Current/Prior Leadership Positions**

   Include current and prior leadership positions with position titles and dates of service and notable responsibilities.

2. **Candidate's Statement of Interest**

   Discuss (not more than 500 words) why you want to be a member of the MSS Governing Council, what you consider to be your major strengths/qualifications for the position, and what benefits you believe are likely to result from your participation.

3. **Dean's Signature - Required**

   Click here to download the document

4. **Endorsements/Letters of Recommendation - Optional**

   Your Speakers will allow the inclusion of 2 letters of endorsement in the Election Manual: one optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in, and one optional letter of endorsement by staff of the state society from the state the candidate attends medical school. No other letters of endorsement may be included in the Manual.

5. **Electronic Photo**

   To maintain photo quality, send an electronic photo (.jpeg) directly to mss@ama-assn.org for inclusion in the Election Manual.

6. **Internal Operating Procedures**

   It is a requirement for all candidates to review the Campaign Rules within the AMA-MSS Internal Operating Procedures in its entirety before beginning their respective campaigns. AMA-MSS IOPs

Conflict of Interest Policy

Please review carefully the AMA's Conflict of Interest Policy and Council Principles, which provide explanatory text and examples. Individuals who are successful in seeking an AMA Section Governing Council leadership position will need to complete and return a conflict of interest disclosure form.

If you are seeking nomination/appointment to a leadership position in another organization, please also

review carefully that organization's conflict of interest policy to determine you will be able to comply. Please also familiarize yourself with the other organization's requirements/instructions for completion of any disclosure form.

As you carefully review these documents, please also consider if there are pending matters, or matters which you anticipate may occur during your term of office, which could, in your view, reasonably be anticipated to adversely impact your license to practice medicine or your ability to discharge fully the duties you are seeking--without embarrassment to yourself or to the AMA (or the other organization).

If you have questions about these documents [including how to complete the conflict of interest disclosure form if you are elected/appointed], the AMA's General Counsel is available to provide guidance. Please contact Beth LaRocca, senior division counsel, at elizabeth.larocca@ama-assn.org, or Jacqueline Krupka, executive assistant, at jacqueline.krupka@ama-assn.org.

*__Please confirm, by checking below, that you have reviewed the__ AMA's Conflict of Interest Policy __and__ __Council Principles____, understand the guidance provided above, and, if elected/appointed to an AMA leadership position, will at that time complete the AMA conflict of interest disclosure form.__

- ☒ Yes

*Upload all materials (#1 - 4) in one complied PDF document. Please include your name in the title. Send your photo to mss@ama-assn.org and notify us if you have any questions with your submission.

Dear AMA-MSS colleagues:

It is with great excitement that I announce my candidacy for Chair-Elect of the American Medical Association's Medical Student Section.

My AMA journey began at the end of my M1 year. I attended the A-17 meeting as the very first delegate representing my school's brand new AMA chapter. I remember being awestruck by the wealth of knowledge, the passion, and the camaraderie of the AMA-MSS. I left inspired and motivated, reporting back to my campus about all of the excitement that took place in Chicago-from the resolutions discussed in our MSS Assembly, such as "Reproductive Health Care in Religiously-Affiliated Hospitals" and "Defending Federal Child Nutrition Programs," to the Medication Take Back National Service Project.

I was eager to become involved within our MSS after attending my first meeting. However, being from a new medical school in rural Wisconsin, I was unclear on how. With the help of some incredible mentors, I was able to find an AMA-MSS standing committee that best aligned with my skill set and passions: the Committee on Medical Education. On CME, I have been able to shape both AMA-MSS and AMA policy through resolution review and report writing on pivotal topics such as standardized video interviewing, USMLE exams, and access to medical education.

CME not only allowed me to ignite my passion for healthcare policy, but it also lit the torch for my love of mentorship. At A-17, I was inundated by the resolution writing process and lost in translation with the assembly's vernacular of "Parliamentary Procedure." However, I was able to navigate through the seemingly convoluted process with guidance from my Region 2. After being a grateful recipient of outstanding mentorship, I was thrilled with the opportunity to pay it back by serving as the Chair of Region 2 and as the Co-Chair of CME. In both of these positions, I found true joy in helping develop and foster future leaders of our AMA-MSS.

If honored to serve as the 2020-2021 AMA-MSS Chair, I will strive to DIG a solid infrastructure so that future MSSers can influence national healthcare policy and grow into our next generation of leaders. My platform is as follows:

Diversity: Our MSS is only as strong as its members' voices. We must work to recruit members from a variety of backgrounds to spur our section's innovation and growth.
Investment: Our MSS is full of the next generation of leaders! Through supporting our regions and standing committees, we can work together to ensure that we tap into our full potential.
Grassroots: Medical students have led the way on multiple grassroots efforts on a variety of topics such as gun violence. Improving our ability to mobilize and take action will enhance our overall political prowess.

Thank you for your consideration. Please do not hesitate in reaching out if you have questions or feedback. I always welcome the opportunities for learning from others. I look forward to seeing new and familiar faces at I-19!

Sincerely,
Stephanie M. Strohbeen

STEPHANIE M. STROHBEEN

702 WERLE AVENUE
WAUSAU, WI 54401
651.303.6227
SSTROHBEEN@MCW.EDU

EDUCATION

2016 – Present — MEDICAL COLLEGE OF WISCONSIN – CENTRAL WISCONSIN (MCW-CW), WAUSAU, WI

Doctorate of Medicine anticipated May 2021

2012 – 2015 — UNIVERSITY OF WISCONSIN – RIVER FALLS (UWRF), RIVER FALLS, WI

Bachelor of Science in Biology with Biomedical Emphasis
Minor: Chemistry
Honors Program

LEADERSHIP

AMERICAN MEDICAL ASSOCIATION – MEDICAL STUDENT SECTION (AMA-MSS)

June 2018 –June 2019 — AMA-MSS Region 2, Chair

- Plan and facilitate region business meetings.
- Serve as a mentor and assist in fostering resolution writing.
- Develop and launch informational webinars for region members.
- Coordinate national, regional, and community-based advocacy and public health efforts.
- Serve as Liaison between the AMA-MSS Governing Council and Region 2 members.

July 2017 – Current — MSS Committee on Medical Education, Co-Chair (2019-20), Vice Chair (2018-19), Member (2017-18)

- Orchestrate the research and composition of assigned reports
- Attend meetings to discuss the direction, barriers, and suggestions to advancement of medical education.
- Plan programming for National meetings
- Serve as a mentor and assist in fostering resolution writing.
- Participate in the AMA-MSS internal review process for resolution for National meetings.

A-18, I-18 — Reference Committee, Member

- Work with the Reference Committee Chair and other members of Reference Committee to develop recommendation on resolutions and reports.

March 2018 – March 2019 MCW-CW, Co-President

- Oversee the functions and operations of our AMA-MSS Chapter.
- Provide clear communication for chapter members on national, regional, and local events.
- Lead grassroots advocacy efforts to help shape the future of medical education and medical practice in Wisconsin.
- Collaborate among all three MCW campuses and the University of Wisconsin School of Medicine and Public Health to promote advocacy efforts, professional development, and networking opportunities.
- Serve as a mentor and assist in fostering resolution writing.

November 2017 – November 2018 AMA Foundation MSS Region 2 Liaison

- Assist with A-18 Foundation programming to increase communication between different section and AMAF.

October 2017 – February 2018 MCW-CW, Community Chair

- Arranged for Naloxone training for our medical students, members of our faculty and staff, and community partners.

June 2017 – Current MCW-CW, Delegate

- Serve as MCW-CW's first delegate in representing the student's voices at AMA-MSS.
- Serve as MCW-CW's delegate for Wisconsin Medical Society meetings.

AMERICAN MEDICAL WOMEN'S ASSOCIATION

August 2016 – March 2018 Medical College of Wisconsin – Central Wisconsin Branch
Secretary

- Prepared and disseminated monthly meeting minutes.
- Facilitated efficient meetings by assisting the Chapter President maintain order according to Robert's Rules of Order.
- Contributed to the compilation of online resources for the Chapter to utilize in preparing future meeting and events.

WISCONSIN MEDICAL SOCIETY

April 2018 – Present Medical College of Wisconsin
Board of Directors Student Representative (2019-20), Elect (2018-19)

- Represent MCW students from all three campuses on the board that oversees the activities and direction of our state medical society.

OTHER LEADERSHIP

April 2018 — MCW - LCME Accreditation, Curriculum
Student Reviewer
- Assisted MCW faculty and staff in a review process of current curriculum to ensure compliance with LCME requirements.

August 2016 – March 2018 — MCW Student Wellness Organization of Central Wisconsin
Treasurer, Liaison to MCW – Milwaukee
- Served as a member of the board and a liaison to provide services such as yoga, bagel and yogurt snack bar, chair massages, and outdoor recreation activities to medical students of the MCW-CW campus.

POLICY

AMERICAN MEDICAL ASSOCIATION – HOUSE OF DELEGATES

- *Support for Requiring Investigation into Deaths of Children in Foster Care* (A-19)

AMERICAN MEDICAL ASSOCIATION-MEDICAL STUDENT SECTION

- *Support for Requiring Investigation into Deaths of Children in Foster Care* (I-18)
- *Committee of Medical Education Report,* Report of the Medical Student Section Governing Council (I-18)
- *Policy Sunset Report for 2012 AMA-MSS Policies,* Report of the Medical Student Section Governing Council (I-17)

WISCONSIN MEDICAL SOCIETY

- *Support for Requiring Investigation into Deaths of Children in Foster Care* (Annual 2019; referred)
- *Elimination of Prior Authorization for Buprenorphine* (Annual 2018)

RESEARCH AND PUBLICATIONS

August 2018 — Strohbeen S, Agostini B, Weisholtz Y, Johnson CA, Le T. "Spinal Cord Lesions." ScholarRx Curriculum Project: Neurology. Projected Publication November 2018.

Strohbeen S, Agostini B, Weisholtz Y, Johnson CA, Le T. "Spinal Nerves and Landmark Dermatomes." ScholarRx Curriculum Project: Neurology. Projected Publication November 2018.

Strohbeen S, Agostini B, Weisholtz Y, Johnson CA, Le T. "The Ear: Anatomy and Physiology." ScholarRx Curriculum Project: Neurology. Projected Publication November 2018.

Strohbeen S, Agostini B, Weisholtz Y, Johnson CA, Le T. "The Eye: Anatomy and Physiology." ScholarRx Curriculum Project: Neurology. Projected Publication November 2018.

2017 – Present

Benjamin J. Herdrich, M.D., Principle Investigator
Surgical Associates , Wausau, WI
"Local Clinical Outcomes of Drug- coated Balloon Therapy for the Treatment of Superficial Femoral and Popliteal Lesions and the Impact of Reimbursement on Treatment Decisions: A Retrospective Review"

2016 – 2018

MCW-CW, PHYSICIAN IN THE COMMUNITY PROJECT
PRESENTED AT MCW-CW PROJECT SHOWCASE, AUGUST 2018
Amy Prunuske, Ph.D., Faculty Mentor
Blake Opal-Wahoske, Community Mentor
"Enhancing Wausau's Walkability"

2015

UW – RIVER FALLS, SUMMER SCHOLARS PROGRAM
Timothy Lyden, Ph.D., Faculty Mentor, Biology Department
"Modeling Trophoblast Early Implantation Using 3D Choriocarcinoma Artificial Tissues"

WORK EXPERIENCE

2010 – 2013

SAINT CROIX ORTHOPAEDICS, STILLWATER, MN
Certified Medical Assistant, Clinical Assistant
- United Way Committee, member

2008 – 2010

HEALTHEAST OAKDALE CLINIC, OAKDALE, MN
Certified Medical Assistant, Clinical Support Staff, Laboratory

2006 – 2008

AMERICAN RED CROSS, SAINT PAUL, MN
Certified Medical Assistant, Collection Specialist

COMMUNITY SERVICE

May 2018 – Present

Marathon County Humane Society Volunteer
- Act as a dog advocate consisting of walking and allowing for enrichment time for the dogs, as well as helping them find forever homes.

March 2018 – May 2018

LENA Childcare
- Care for children whose parents are attending meetings as part of the local LENA project.
- The LENA project aims to increase interactive talk with children during development.

September 2016 – June 2019	Girl Scouts Troop Leader and Volunteer • Working with troop members to develop a community service project to earn their Bronze Badge • Prepare and lead programming to help the troop earn badges. • Assist in cookie sales for the troop.
February 2018, April 2017	High Five 4 College • Interacted with middle school students to help them explore health care field options.
May 2017	Ice Age Trail Alliance • Participated in a County Chapter effort to build new trail along the Ringle Segment of the Ice Age Trail.
April 2017	Jubilee House • Prepared and served dinner for those in need in the Wausau area.
February 2017	Aspirus Weigh to Go • Assisted with the opening events of a community wellness challenge.
March 2014 – May 2016	New Richmond Area Soccer • Served as coach for U11 girls team. • Served as assistant coach and parent liaison for U10 girls team.
June 2013 – May 2016	New Richmond Area Centre • Served as a volunteer working on tasks from the Executive Director including clerical work, assistance with community events, stocking, inventory, and making guests feel welcome.

HONOR AND AWARDS

2017	MCW – CW Outstanding Clinical Skills Award • Presented by the Assistant Dean of Clinical Learning to the M1 Student who has displayed particular acuity and skill in their clinical interactions.
2016, 2017, 2018	Agustin A. Ramirez, Jr. Family Foundation Scholarship
2015	Senior Merit, UWRF
2015	UWRF Summer Scholars Grant Recipient
2015	Phi Kappa Phi National Honor Society, Inductee, Student Vice President
2008	HealthEast Clinical Vision Award • Presented for going above and beyond expectations in workplace performance.

PROFESSIONAL ORGANIZATION MEMBERSHIPS

- AMERICAN MEDICAL ASSOCIATION

- Wisconsin Medical Society
- Marathon County Medical Society
- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Surgeons
- American Medical Women's Association

Student Organizations and Interest Groups

- OB/GYN and Pediatrics Interest Group
- Student Surgical Society, Surgical Mentorship
- Wilderness Medical Society

Hobbies and Wellness Activities

- Being outdoors: hiking, running, camping, yoga, exploring with my family and dogs
- Rock Hunting
- Beginner Ukulele Player

Medical Student Section Governing Council Application

Dean's Signature

The elected AMA Medical Student Section (MSS) Governing Council member should be available to attend the AMA MSS Governing Council Orientation (Jul. 14-15, 2017), the AMA National Medical Student Interim and Annual Meetings (Nov. 9-11, 2017; Jun. 7-9, 2018), and the AMA Medical Student Advocacy and Region Conference (Mar. 8-10, 2018).

The Interim meeting is held each November and requires at least a 4-day time commitment (Thursday – Sunday). The Annual meeting is held each June in Chicago and also requires at least a 4-day commitment. The positions of Chair, Delegate, and Alternate Delegate are required to remain for the AMA House of Delegates meeting which entails an additional 2 days at Interim and 3 days at Annual. The AMA Medical Student Advocacy and Region Conference is a 3-day meeting (Thursday – Saturday) held early March in Washington, D.C.
Governing Council Meetings are held in conjunction with these three main meetings plus a stand-alone orientation for 1.5 days in July.

Please acknowledge that you have discussed this time commitment and made appropriate arrangements with your dean or clinical preceptor by signing below. The signature of your Dean or Advisor is required to acknowledge the time commitment involved in a Governing Council position and to verify that you are a student in good-standing with your medical school.

Candidate: Stephanie Strohbeen

Dean/Advisor: _____ MD

SR ASSOCIATE DEAN FOR MEDICAL EDUCATION

Wisconsin Medical Society
Your Doctor. Your Health.

October 18, 2019

Medical Student Section
American Medical Association
AMA Plaza
330 North Wabash Ave., Suite 39300
Chicago, IL 60611-5885

RE: Stephanie Strohbeen– Endorsement for AMA-MSS Chair

Dear Members of the Medical Student Section:

The Wisconsin Medical Society (WMS) and its American Medical Association Delegation are proud to endorse the nomination of Stephanie Strohbeen for AMA-MSS Chair.

We first came to know Stephanie when she served in the AMA-MSS Assembly at A'17 as the first delegate from Medical College of Wisconsin's (MCW's) Central Wisconsin (WI) campus. She quickly became integrated into the AMA delegation and is a leader in organized medicine. She recently served as Region 2 Chair and is Co-Chair of the MSS Committee on Medical Education, and previously served as Region 2 liaison to the AMA Foundation and as Reference Committee member.

In Wisconsin, Stephanie serves on the WMS Board of Directors and is Co-president of the AMA chapter at the MCW Central Campus. She actively coordinates AMA activities with our AMA delegation and the 3 other student chapters in WI.

Stephanie displays three key qualities of an outstanding leader. First, **perseverance**. Stephanie continuously engages her regional students in increase their participation in WMS and AMA activities such as Doctor Day, resolution discussions, student meetings and house of delegates meetings. Second, **guardianship**. Stephanie always works in the best and shared interest of the group she is representing. Third, **adaptability**. Stephanie rises to the occasion to meet delegation needs, for example, she served as alternate delegate for region 2 at A'19 with short notice. She is dependable in her ability to adapt to a situation and highlights the benefits of the change. Stephanie was awarded the Outstanding Clinical Skills Award in her first year of medical school for displaying acuity and skill in her clinical interactions.

Stephanie's extensive experience with the AMA, enthusiasm for health policy, and steadfast commitment to bettering the profession and the health care system for the welfare of our patients are all traits that make her an ideal candidate for this position. The WMS and our AMA delegation wholeheartedly supports her candidacy for AMA-MSS Chair. She is an outstanding candidate!

Sincerely,

Tosha Wetterneck, MD, MS, FACP
Chair, Wisconsin Delegation to the AMA

Jerry Halverson, MD, DFAPA
Chair, Board of Directors
Wisconsin Medical Society

Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org •



Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Neha (First) Agrawal (Middle) (Last)

Address: 1910 Valley Rd Apt 606 (Street address)

City, State, Zip: Reno (City) NV (State) 89512 (Zip)

Telephone: 908-868-2707 (Day) (Evening)

Email address: nagrawal@unr.edu

Medical School: University of NV Reno

Expected graduation: 2021

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Catherine ONara

Signatory's name and title (Please print): Catherine O'Nara, ED State: NV

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: CSing

Signatory's name and title (Please print): Cherie Singer

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Neha Agrawal

1910 Valley Rd, Apt 606
Reno, NV 89512
(908) 868 2707
nagrawal@med.unr.edu

EDUCATION

M.D., University of Nevada, Reno School of Medicine, Reno, NV — 2021, anticipated
Scholarly Concentration in Narrative Medicine

B.A. Public Policy Studies, Duke University, Durham, NC — 2017

HEALTH POLICY LEADERSHIP EXPERIENCE

American Medical Association Region 1 Chair — 2019-2020
Organize Region 1 Conference, coordinate Region 1 activities and meetings

Regional Delegate to AMA House of Delegates — 2019-2020
Resolution reviewer and representative of medical student interests at AMA Interim Conference House of Delegates

Stop the Bleed Certified Trainer — 2019-2020

Moderated Dialogue with 19th Surgeon General Dr. Vivek Murthy — Fall 2018
Conducted Q/A session at the University of NV Reno School of Medicine

Regional Alternate Delegate to AMA House of Delegates — Fall 2018
Resolution reviewer and representative of medical student interests at AMA Interim Conference House of Delegates

Design Thinking in Healthcare Programming Co-Lead — Fall 2018
Planned and organized AMA Interim programming event on innovation in healthcare

AMA-MSS Committee on Economics and Quality in Medicine Member, — 2018-2020
Generate national conference programming, produce educational materials, and review economics resolutions

Nevada State Medical Association Steering Committee Member — 2018-2020
Responsible for o*rganizing NV medical student section*

American Medical Association Region 1 Community Service Chair — 2018-2019
Create and coordinate community service projects across Western states for medical students, planned Regional Conference programming events, projects: Stop the Bleed, Health Care Navigators

AMA UNRSOM Chapter President, Reno NV — 2018-2019
Oversee chapter, work with local, state, and national organizations in advocacy and on health policy resolutions

Women's Medical Student Association Chapter Co-President, Reno NV — 2018-2019
Explore women's health policy issues, organize networking, mentorship and speaker events with female physicians and medical students

HEALTH POLICY RESEARCH EXPERIENCE

Research, Dr. Ron Swanger, Reno Diagnostic Centers, NSMA President — Present
Neuroradiology for Undergraduate Medical Education

Research Intern, Dr. Hillary Johnson-Jahangir, University of Iowa, Department of Dermatology — July 2018- 2019
Shared Decision Making in Rural Mohs Micrographic Surgery Patients
This project was an analysis of a needs assessment for a rural patient population undergoing cutaneous surgery for the purpose of creating a shared decision making model.
Perioperative Antibiotic Use in Cutaneous Surgery
This project was a review article on the use of antibiotics perioperatively in the prevention of post-surgical infections.

Research Intern, Dr. Gillian Sanders-Schmidler, Duke Margolis Center for Health Policy, Duke Clinical Research Institute, Department of Medicine — 2016
Cost-effectiveness Analysis in Healthcare and Medicine
This research experience focused on analyzing value-based guidelines, payment delivery reform, and the use of cost-effectiveness analysis in healthcare. The clinical research component of the internship emphasized comparative-effectiveness analyses for a variety of treatment interventions across specialties.

Resolutions

Protecting Medical Student Access to Abortion Education and Training — November 2019
Pending I19

Protecting Immigrant Health and Well-Being — November 2019
Pending I19

Supporting External Accountability for ICE and CBP — November 2019
Pending I19

Support for Housing Modification Policies — November 2018
Resolution at AMA Interim 2018, primary author, referred for study

Support for Children with Incarcerated Parents — November 2018
Resolution at AMA Interim 2018, passed AMA A'19

Advocate to End Child Marriage — November 2018
Resolution at AMA Interim 2018, reaffirmed AMA MSS

Health Policy Conferences

Nevada Cancer Coalition, Reno, NV — September 2019

NCCN Hematologic Malignancies, San Francisco, CA — September 2019

AMA National Advocacy Conference, Washington DC — February 2019

AMA Interim Conference, National Harbor, MD — Nov 2018
Produce and debate health policy resolutions

Nevada State Medical Association Annual Conference, Las Vegas NV — Sept 2018, 2019
Medical Student Delegate for Washoe County

AMA Annual Conference, Chicago IL — June 2018, 2019
Chapter delegate representing NV at the medical student section

Medical Student Advocacy and Region Conference, Washington D.C. — March 2018
Advocated for AMA medical student issues at Capitol Hill

CLINICAL EXPERIENCE

National MS Society Clinical Mentorship Fellowship, Duke University Hospital, Durham NC — June 2018

Preceptorship in Family Medicine with Dr. Angelica Andrade, Reno NV — Spring 2018

Preceptorship in Pediatrics with Dr. Robin White, Reno NV — Fall 2018

Student Provider, UNR Med Student Outreach Clinic — 2017-Present

VOLUNTEER EXPERIENCE

Plastic Surgery and ENT Student Interest Group Coleader — 2018-2019
Coordinate medical student meetings and educational events with physicians

Reconstructive Surgery Service Learning, Duke University, Durham, NC — 2017
Volunteered at clinic and interviewed patients at Duke Hospital, 30 hours

Children with Chronic Illness, Duke University, Durham NC — 2015
Created a documentary project for a child with chronic illness, organized exhibit, and taught photography, 30 hours

Medical Documentary Project in Reconstructive Surgery, Duke University, Durham NC — 2014
Documented microsurgical breast reconstruction for women with breast cancer, 30 hours

PROFESSIONAL MEMBERSHIPS
American Medical Association, Nevada State Medical Association, Washoe County Medical Society, American Medical Women's Association

LANGUAGE SKILLS
Hindi, proficient

PERSONAL INTERESTS
Photography, Aikido, Viola

Diversity Statement

As women in organized medicine have traditionally been underrepresented, I will bring diversity to the position through my experiences as a female Indian American medical student. I value the perspectives of underrepresented populations and have studied health disparities in depth during my public policy degree program. I also am a dual US and Finnish citizen, and have lived in 8 different states across different parts of the country, bringing a diverse set of experiences from living in many different places.

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- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Apoorva (First) Bhaskara (Last)

Address: 3321 E Fort Lowell Rd (Street address)

City, State, Zip: Tucson (City) AZ (State) 85716 (Zip)

Telephone: (480)-221-2317 (Day)

Email address: apoorvabhaskara@email.arizona.edu

Medical School: University of Arizona College of Medicine- Tucson

Expected graduation: 2022

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Ronnie Dowling, MD,Chair State: AZ

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____, MD

Signatory's name and title (Please print): GEORGE T. FANTRY
SENIOR ASSOCIATE DEAN, STUDENT AFFAIRS

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Email: mss@ama-assn.org

Apoorva Bhaskara

3321 E Fort Lowell Rd, Tucson, AZ 85716
(480)-221-2317 | apoorvabhaskara@email.arizona.edu

Education

University of Arizona College of Medicine- Tucson (UACOM-T) **2018- Anticipated 2022**
Doctor of Medicine

University of Arizona (UA) **Graduated May 2018**
Bachelor of Science in Biomedical Engineering
Minors in Mathematics and Biochemistry
3.969 GPA, Summa Cum Laude with Honors

Research Experience

Global Health research, Shirati, Tanzania **Summer 2019**
Lab of Dr. Kevin Dieckhaus, University of Connecticut School of Medicine; in collaboration with Dr. Melissa Moore, University of Arizona College of Medicine- Tucson
Project: Prevalence and Understanding of Sickle Cell Disease (SCD) in Rorya District, Tanzania

- Tested 1000 children under the age of five were for SCD or SCD trait with a finger prick, utilizing rapid hemoglobin type testing, and referring those with a positive test for medical care
- Approximately 30% of participants were found to be carriers, with 2-3% positive for SCD, higher than previously published estimates of the surrounding area

Medical Student Researcher, University of Arizona **2018- Present**
Lab of Dr. Fariba Donovan, Valley Fever Center for Excellence
Project: Rapid Lateral Flow Assay (LFA) for Rapid Diagnosis of Coccidioidomycosis (Valley Fever) to Reduce the Unnecessary Use of Antibacterial Drugs

- Testing the specificity and sensitivity of a newly developed rapid LFA test compared to enzyme-linked immunosorbent assay (EIA), the current gold standard in a clinical setting
- Review charts from participants to assess the impact of symptoms, immunocompromised status, radiographic results, immune markers, and inpatient/outpatient on the LFA results

Undergraduate Researcher, University of Arizona **2014- 2018**
Lab of Dr. Anita Koshy, Immunobiology department
Project: To characterize the strain-specific CNS neuroinflammatory response of the *Toxoplasma gondii* parasite in brains of mice

- Quantified how the response of immune cells most implicated in the CNS toxoplasmosis differs between different *Toxoplasma* strains
- Performed immunohistochemistry stains on mouse brains to obtain CD3 T-cells counts, Iba-1 macrophage response parameters, and other quantitative information for mice infected with different strains of *Toxoplasma*

Summer Intern, Icahn School of Medicine at Mount Sinai **Summer 2017**
Lab of Dr. Benjamin Chen, Virology department
Project: Examining genetic determinants that control HIV immune evasion during cell-to-cell infection

- Created a saturation mutagenesis library in the cytoplasmic tail of the envelope (Env)
- Performed viral challenges with the manufactured HIV mutants on host cell lines to identify the key genetic determinants that influence cell-cell infection, cell-free infection, and resistance versus sensitivity to different antibodies

Helios Scholar Intern, Translational Genomics Research Institute **Summer 2016**
Lab of Dr. Bridget Barker, Northern Arizona Center for Valley Fever Research
Project: Analyzing the function of gene CIMG_00509 in the fungus, *Coccidioides spp.*, which causes Coccidioidomycosis (Valley Fever), in relation to host immune response

- Analyzed previously sequenced Coccidioides genomes for conservation of the gene throughout the two major species and similarities to toxic proteins
- Introduced a manufactured peptide of the target gene to alveolar macrophage cells and quantified the immune response through cytokine expression levels

Publications

1. Tuladhar S, Kochanowsky J, **Bhaskara A,** Ghotmi Y, Koshy A. "*Toxoplasma gondii* strain-specific acute immune responses shape the early neuroinflammatory response." *Submitted* 2018.

Poster Presentations

1. **Bhaskara A,** Chen B, Li H. "Screening for Genetic Determinants in HIV-1 Env Cytoplasmic Tail that Influence Infectivity and Sensitivity to Neutralizing Antibodies." Icahn School of Medicine at Mount Sinai Summer Undergraduate Research Program Symposium, New York, NY; August 2017.

2. **Bhaskara A,** Barker B, Teixeira M, Doyle A, Mead H. "Valley Fever: Analyzing the Function of CIMG_00509 in *Coccidioides spp*." Translational Genomics Research Institute Helios Scholars Symposium, Phoenix, AZ; July 2016.

Leadership and Activities

Alternate delegate, American Medical Association (AMA) **2018- present**

- Attended the 2019 Annual AMA Conference- Medical Student Section and House and Delegates

Coordinator, Infectious Disease Interest Group **2018- present**

- Organize talks from Infectious Disease physicians in a variety of specialties
- Help students who are interested in Infectious Diseases find opportunities for shadowing and research

Coordinator, UA COM Make-A-Wish chapter **2018- present**

- Organize talks from Make-A-Wish leaders to recruit medical students to volunteer as Wishmakers
- Act as liaison between the UA COM CUP (Commitment to Underserved Populations) program and the Southern Arizona Make-A-Wish organization
- Record volunteer hours for Make-A-Wish volunteers in the college of medicine
- Organize a team for the Tucson Walk for Wishes and fundraise

Coordinator, Health for the Homeless **2018- present**

- Organize monthly clinic volunteer days at the Z-mansion Sunday event where unstably housed individuals are offered free clothing, food, and medical care
- Coordinate attending physician availability and correspond with Z-mansion staff about what help is needed

Docapella (Medical Student Acapella Group) **2018- present**

- Perform at hospitals, nursing homes, and various college of medicine events

Volunteering

Wish Granter for Make-A-Wish Foundation Arizona **2018- present**

- Make-A-Wish arranges once in a lifetime experiences for children diagnosed with critical illnesses
- Act as a liaison between wish children and the foundation to meet with wish families, determine the child's one true wish, and help coordinate details of the wish
- UA COM Make-A-Wish Volunteer Coordinator

Health for the Homeless **2018- Present**

- Volunteer at a temporary triage clinic for Tucson's homeless population
- UA COM Volunteer Coordinator

Clinical Research Enrollment at Banner Emergency Department **2017- 2018**

- Enroll eligible patients in various current clinical trials
- Work closely with doctors and nurses in patient care team

Volunteer at University of Arizona Campus Health Clinic **2016- 2017**

- Helped admit patients into urgent care and take vital signs
- Shadow doctors in urgent care, general medicine, and women's health
- Aid the nurses and doctors in certain procedures
- Organization and promotion of flu shot clinics around campus

Vive Peru Volunteer **Summer 2015**

- Worked in underserved and understaffed clinics in Trujillo, Peru
- Ran medical campaigns in rural communities
- Organized educational events in rural communities on public health issues such as water safety and infection control

Work Experience

Middle/High School Tutor **2016- present**

- Tutoring middle and high school students who are struggling in math, science, reading/writing, and helping with general study skills

Skills and Certifications

- Certified Nursing Assistant
- CPR Certified
- Community Emergency Response Team (CERT) certified
- Programming skills: C Language (intermediate), Matlab (basic)
- Microsoft Office (advanced)



Diversity Statement

My parents immigrated to the US from India shortly before I was born to create a new life for themselves and their children. Unfortunately, the road leading to this goal was not always direct; they were met with a series of challenges from constant relocation due to work and visa issues.

Somewhere in the mess of accents I was exposed to living in the US, India, and even England, I developed a speech impediment which prevented me from saying the letter 'r' and thus led me to mispronounce many words. As we were constantly moving around, I was never able to go attend proper speech therapy to solve this early on. My classmates constantly teased me, so I started talking less and less in school. I would even dread introducing myself to new people because I could not pronounce the "r" in my own name.

At the age of ten, I decided to join my school choir. I loved the feeling of singing because my voice, which had been defined by my speech impediment for so long, could be drowned out by the rest of my classmates. Soon, I also began Indian classical music. I quickly realized though that unlike chorus, this style required performing alone or in small groups. My voice would take center stage.

I had two options at this point: succumb to my fears and never sing again or take control of my life and pursue my passion for singing. Thankfully, I decided on the latter. By high school, I decided that I was done being ashamed of my own voice. I had always assumed that my voice was an invariable part of my body that I had little control over. However, through music, I realized it was an ability that I could train and refine. After watching countless Youtube tutorials and practicing for months in front of the mirror, I mastered the rolling 'r' sound that had eluded me for so many years prior. My pronunciation while singing improved over time, and I slowly worked to incorporate it into my everyday speech by practicing until it became instinct.

Overcoming my speech impediment helped me grow into a more confident speaker, and taught me that I can always better myself, both personally and professionally, through practice and dedication. It has also taught me a great deal about empathy, because you never know what someone has gone through or has had to do to get where they are. I am working to carry this perspective into the AMA to not only fight for what I think is right, but understand the other side as well. By understanding someone else's background and why they are standing on the other side of an issue, we can craft better, more inclusive policies.

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- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Kevin		Chu
	First	Middle	Last
Address:	638 Parnassus Avenue		
	Street address		
City, State, Zip:	San Francisco	CA	94122
	City	State	Zip
Telephone:	(408) 887-9166		
	Day	Evening	
Email address:	yngjast@gmail.com		
Medical School:	UCSF School of Medicine		
Expected graduation:	May 2022		
AMA-MSS Region (1-7):	1		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

Chq

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Brandon Marchy

Signatory's name and title (Please print): Brandon Marchy, Delegation Coordinator State: CA

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Lee Jones, MD

Signatory's name and title (Please print): Lee Jones, M.D. Associate Dean for Students

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Email: mss@ama-assn.org

CURRICULUM VITAE

KEVIN CHU

638 Parnassus Avenue • San Francisco, CA 94122 • (408) 887-9166 • kevin.chu@ucsf.com

EDUCATION

- **University of California, San Francisco School of Medicine** — **San Francisco, CA**
  - *MD anticipated in May 2022* — *08/2018 – Present*
- **Harvard Business School Online** — **Boston, MA**
  - *CORe: Credential of Readiness, Pass with High Honours* — *10/2017 – 03/2018*
- **University of California, Berkeley** — **Berkeley, CA**
  - *BA, Summa Cum Laude, Molecular and Cell Biology – Neurobiology* — *08/2013 – 05/2016*

POLICY EXPERIENCE

- **AMA House of Delegates Coordination Committee (HCC) Member** — **San Francisco, CA**
  American Medical Association, Medical Student Section (AMA-MSS) — *01/2019 – Present*
  - Thoroughly review resolutions and reports submitted to the AMA House of Delegates (HOD), and then form a well-informed position with the support of student members of state delegations
- **Vice Chair of Legislative Affairs** — **San Francisco, CA**
  California Medical Association, Medical Student Section (CMA-MSS) Governing Council — *10/2018 – Present*
  - Educate and update the CMA-MSS on state and federal legislative issues impacting medical students
  - Facilitate student participation in legislative advocacy and involvement in statewide campaigns
- **Co-President of UCSF AMA/CMA Chapter** — **San Francisco, CA**
  American Medical Association (AMA) and California Medical Association (CMA) — *11/2018 – Present*
  - Lead monthly meetings and mobilise students to write resolutions shaping internal AMA/CMA policy
- **UCSF Delegate to the AMA** — **San Francisco, CA**
  American Medical Association, Medical Student Section (AMA-MSS) — *10/2018 – Present*
  - Serve as UCSF's voting representative on items of business at AMA Annual and Interim Meetings
- **Ambassador Constituent Team (ACT) Lead** — **San Francisco, CA**
  American Cancer Society Cancer Action Network (ACS CAN) — *04/2014 – 12/2018*
  - Served as the key volunteer contact for our members of Congress and state elected officials
  - Prepared ambassadors for legislative meetings in Sacramento, CA and Washington, DC
  - Collective advocacy successes include four consecutive $2 billion increases in NIH funding, Prop 56 and raising California's minimum legal sale age for tobacco from 18 to 21
  - Founded *Bay Area Young Professionals of the American Cancer Society (BAYPACS)* in September 2017 to connect millennials to ACS programmes and lend support to cancer-fighting initiatives

LEADERSHIP EXPERIENCE

- **UCSF Choosing Wisely STARS Representative** — **San Francisco, CA**
  Choosing Wisely — *01/2019 – Present*
  - Attended the 2019 Choosing Wisely STARS Leadership Summit at the University of Texas at Austin Dell Medical School to learn about tools for advancing high value care
  - Formalised a faculty-student partnership with endorsement of the Center for Healthcare Value to support further integration of value-based care education into undergraduate medical education
  - Enlisted students in targeted interventions that reduce unnecessary use of tests and treatments
- **Foundations 1 Operations Committee Member** — **San Francisco, CA**
  UCSF School of Medicine Curriculum Governance — *11/2018 – Present*
  - Meet with deans to decide policy on educational initiatives in the preclerkship phase of the curriculum
  - Participate in monthly Student Governance Committee meetings to centralise student opinion and present it to the administration
- **Co-President** — **San Francisco, CA**
  Scrubs Addressing the Firearm Epidemic (SAFE), UCSF Chapter — *10/2018 – Present*
  - Work with a coalition of clinicians and researchers to develop a curriculum that teaches medical trainees to effectively communicate with patients about how to reduce the risk of firearm injury
  - Spearhead educational events including a week of action featuring a multidisciplinary panel of providers and a discussion with case workers from the Wraparound Project, a local hospital-based youth violence intervention program, about their success in breaking the cycle of violence

- **Dermatology Clinic Director** — **San Francisco, CA**
  UCSF Homeless Clinic — *10/2018 – Present*
  - Coordinate 6 clinics per year, train volunteers and set clinic dates with dermatology faculty preceptors
- **President** — **Berkeley, CA**
  PIH Engage, UC Berkeley Chapter — *08/2014 – 05/2016*
  - Organised meetings with offices of members of Congress to advocate for global health funding and prevent important aid programmes including PEPFAR from getting cut
  - Spoke to presidential candidates at campaign stops in support of stronger health systems, prompting two major candidates to add language about ending the AIDS epidemic to their platforms
  - Raised over $100,000 to fund some of the lifesaving work at Partner in Health (PIH)'s sites and get closer to a world with zero deaths from tuberculosis
  - Established a new global health course in the UC Berkeley School of Public Health

RESEARCH EXPERIENCE

- **Junior Research Specialist** — **San Francisco, CA**
  UCSF Department of Dermatology — *07/2016 – 05/2018*
  - Advisor: Dr Tiffany C Scharschmidt
  - Project: Decoding and Harnessing Microbial Tuning of T Cell Responses in Early Life
- **Undergraduate Researcher** — **Berkeley, CA**
  UC Berkeley Department of Molecular and Cell Biology — *08/2015 – 05/2016*
  - Advisor: Dr Michael Rape
  - Project: Uncovering Roles of Ubiquitylation During Cellular Differentiation
- **Summer Intern** — **Cold Spring Harbor, NY**
  Undergraduate Research Program, Cold Spring Harbor Laboratory — *06/2015 – 08/2015*
  - Advisor: Dr Joshua Dubnau
  - Project: The Transposon Storm Hypothesis of Neurodegeneration
- **Undergraduate Researcher** — **San Francisco, CA**
  UCSF Department of Neurological Surgery — *10/2013 – 05/2015*
  - Advisor: Dr Arturo Alvarez-Buylla
  - Project: Immature Excitatory Neurons Develop During Adolescence in the Human Amygdala

PEER-REVIEWED PUBLICATIONS

- Leech JM, Dhariwala MO, Lowe MM, **Chu K**, Merana GR, Cornuot C, Weckel A, Ma JM, Leitner EG, Gonzalez JR, Vasquez KS, Diep BA, Scharschmidt TC. Toxin-triggered interleukin-1 receptor signaling enables early discrimination of pathogenic versus commensal skin bacteria and limits pathogen-specific tolerance. *Cell Host Microbe*. In press.
- Scharschmidt TC, Vasquez KS, Pauli ML, Leitner EG, **Chu K**, Truong HA, Lowe MM, Sanchez Rodriguez R, Ali N, Laszik ZG, Sonnenburg JL, Millar SE, Rosenblum MD. Commensal Microbes and Hair Follicle Morphogenesis Coordinately Drive Treg Migration into Neonatal Skin. *Cell Host Microbe.* 2017 Apr 12; 21(4):467-477.

PRESENTATIONS

- **Chu K**, Wallace K, Meyer A, Nolasco J. Equitable Growth in Breastfeeding Exclusivity Rates at Discharge. Poster presentation at 2019 CMC Health Improvement Symposium, San Francisco, CA, *May 2019*.
- Leech JM, **Chu K**, Leitner EG, Moon JJ, Diep BA, Scharschmidt TC. Early Priming to Staphylococcal Antigens Sets the Course for Host Immune Tolerance vs. Immunity. Poster presentation at 2017 Staphylococcal Diseases Gordon Research Conference, Waterville Valley, NH, *August 2017*.
- **Chu K**, Krug L, Dubnau J. The Transposon Storm Hypothesis of Neurodegeneration. Oral presentation at CSHL Undergraduate Research Program Final Symposium, Cold Spring Harbor, NY, *August 2015*.

HONOURS AND AWARDS

- First Dan (first-degree black belt), International Taekwon-Do Federation — 2007
- National Merit Scholarship — 2013
- Vannevar Bush 125th Anniversary Fellow at Cold Spring Harbor Laboratory — 2015
- UC Berkeley Regents' and Chancellor's Scholarship — 2013 – 2016
- UC Berkeley University Medal Finalist — 2016
- Facebook Global Digital Challenge Finalist — 2016
- Phi Beta Kappa Junior Inductee — 2016
- UCSF Heiman Research Fellowship Award — 2019

Application for AMA-MSS Regional Delegate and Alternate- 2020

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
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- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Alysa (First) Faith (Middle) Edwards (Last)

Address: 2378 Xanthia Way (Street address)

City, State, Zip: Denver (City) CO (State) 80238 (Zip)

Telephone: 801-541-3277 (Day) (Evening)

Email address: alysa.edwards@cuanschutz.edu

Medical School: University of Colorado School of Medicine

Expected graduation: May 2022

AMA-MSS Region (1-7): R1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Alethia Morgan

Signatory's name and title (Please print): Alethia (Lee) E. Morgan State: CO

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Erik Wallace

Signatory's name and title (Please print): Erik Wallace, MD Assoc. Dean for Colorado Springs Branch

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Email: mss@ama-assn.org

Alysa Edwards

(801)541-3277 ● alysa.edwards@cuanschutz.edu

Education

University of Colorado, Denver, CO — May 2022
Doctor of Medicine
- US Army Health Professions Scholar, 2nd Lieutenant

University of Utah, Salt Lake City, UT — December 2017
Bachelor of Arts in International Studies
- Emphasis in global health, Minor in Biomedical Engineering

Juan Diego Catholic High School, Draper, UT — May 2013

Leadership Experience

American Medical Association — Fall 2018-Present
University of Colorado Delegate, House Coordinating Committee Member
- Lobbied congressional representatives regarding firearm safety, GME, and prescription drug prices at the 2019 Medical Student Advocacy and Region Conference
- Attended and participated in Annual 19 as the CU delegate to the Medical Student Section (MSS), an alternate delegate to the House of Delegates, a Think Tank session presenter, and a policy review team member
- Created and submitted a resolution to the MSS on outdoor recreation for Interim 19
- Evaluated and provided feedback on medical student resolutions in preparation for Interim 19

Colorado Medical Society, University of Colorado — Fall 2018-Present
Policy and Advocacy Chair, MSS Leadership
- Planned and attended educational events for students including policy and advocacy focused lunch lectures, Medical Student Day at the Capitol, and White Coat Wisdom
- Developed fundraising strategies for travel grants in collaboration with Rocky Vista University students
- Represented CMS at student events and assisted in recruiting new student members

Research Experience

Denver Health and Hospital Authority, Denver, CO — Fall 2019-Present
Research Assistant
- Analyze journal articles to evaluate gender differences in academic publications

Bone and Joint Research Lab, Salt Lake City, UT — Fall 2013-Spring 2018
Research Assistant
- Analyzed the ability of osseointegrated implants to form a sufficient skin barrier in animals using histological techniques including cryosectioning, IHC staining, and confocal microscopy
- Developed staining techniques to observe the implant interface and improve visual differentiation between tissues in order to quantify the healing response

Maliheh Clinic, Salt Lake City, UT — Summer 2016-Fall 2016
Survey Distributor and Research Assistant
- Encouraged patients to complete surveys in English and/or Spanish concerning diabetes, provider effectiveness, dental care, and other health issues
- Assisted in translating nutrition classes for English and Spanish speaking patients

Volunteer Experience

Mission Medical Clinic, Colorado Springs, CO — Spring 2019-Present
Medical Student
- Interview, examine, and create treatment plans for uninsured and low-income patients in the Pikes Peak community

Honors Praxis Lab: Gender, Health, and Human Rights — Fall 2016-Spring 2017
Student Coordinator
- Discussed topical issues with community leaders and professionals
- Researched, proposed, and implemented an initiative to increase sexual assault reporting and the availability of resources at the University of Utah sexualassault.utah.edu

4th Street Clinic, Salt Lake City, UT — Fall 2015-Spring 2016
Connect2Health Mentor
- Connected patients experiencing homelessness with resources to cultivate multi-dimensional health
- Provided interpersonal support to patients by working to understand their situation and listening patiently

Alysa Edwards

(801)541-3277 ● alysa.edwards@cuanschutz.edu

Work Experience

Altius Test Prep, Salt Lake City, UT — Fall 2017-Spring 2018
Tutor

- Prepared pre-medical students to take the MCAT through one-on-one instruction, practice exams, and group sessions
- Mentored students in their class schedule/activity selection and medical school application process

College of Engineering, University of Utah — Spring 2016
Computational Methods Teaching Assistant

- Instructed students on how to create computer code using MATLAB to accomplish calculations used in bioengineering
- Graded weekly assignments to ensure original and functional code

Debate Team, Juan Diego Catholic High School — Fall 2013-Spring 2014
Debate Coach

- Researched various topics on public policy, prepared evidence files and arguments, and delivered demonstration speeches
- Worked with students to develop critical thinking and speaking skills in a debate setting

Awards and Achievements

- Cum Laude Graduate
- Undergraduate Research Scholar
- University of Utah Dean's List
- Nicholas and Helen Papanikolas Scholarship
- Presidential Honors Scholarship

Conferences & Courses

- Utah Conference of Undergraduate Research, *St. George, UT* — February 2015
- Undergraduate Research Symposium, *Salt Lake City, UT* — March 2015
- Global Health Extreme Affordability Conference, *Salt Lake City, UT* — January 2017
- Musculoskeletal Disease Seminar, *Salt Lake City, UT* — March 2017
- Colorado Medical Society Annual Meeting, *Vail, CO* — September 2019
- AMA-MSS Region 1 Conference, *Denver, CO* — January 2019
- Medical Student Advocacy and Region Conference, *Washington DC* — March 2019
- Perry Initiative Medical Student Outreach Program, Aurora, CO — March 2019
- AMA Annual Conference 2019, *Chicago, IL* — June 2019
- Army Medical Department Direct Commission Course, *Ft. Sill, OK* — July 2019

Publications and Presentations

- Kamimura, Akiko, et al. (2016) "Factors associated with oral health-related quality of life among safety-net clinic patients." *Journal of Public Health Dentistry* (2016).
- Edwards, Alysa "Understanding the Periprosthetic Microenvironment Surrounding Percutaneous Devices: Use of Simple Immunohistochemical Techniques to Predict Healing Outcomes." *Utah Conference on Undergraduate Research* (2015).
- Davis, D., Edwards, A., South, T., & Wang, M. (2019, June). *Outdoor Recreation and Health*. Presented at the AMA 2019 Annual Meeting, Chicago, IL.

Professional Memberships

- American College of Emergency Physicians
- American Medical Association
- Colorado Medical Society
- Colorado Springs Longitudinal Branch
- CU Emergency Medicine Interest Group
- Emergency Medicine Residents' Association
- HPSP Interest Group
- Urban Underserved Track Scholar

Proficiencies & Languages

- CPR Certified
- Database Research
- MATLAB
- Microsoft Office
- Python
- Spanish, Intermediate-Advanced, Medical

Diversity Statement
Alysa Edwards
MSS Delegate Application 2019

Through my education and identity, I believe I can positively contribute to the diversity of the MSS Delegation. Having studied both engineering and the humanities, my education will allow me to provide a unique view on medicine and patient care when considering issues brought before the MSS and HOD. I can use my knowledge to understand the fine details of medical ideas while keeping in mind the social determinants of health that affect the lives of patients and students alike. Growing up with a Latina mother and white father has given me a unique perspective on race and ethnicity that I believe may also benefit the diversity of the MSS. I recognize the privilege that goes along with my appearance and simultaneously feel that many of my beliefs, attitudes, and interests are shaped by my Latina heritage. As a MSS delegate, I want to rely on my values to help inform my opinion on health issues, facilitate the diversity of student perspective within the MSS, and advocate for all marginalized communities through improved access to quality care.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Drayton (First) Charles (Middle) Harvey (Last)

Address: 414 Via Marisol, Apt 112 (Street address)

City, State, Zip: Los Angeles (City), CA (State), 90042 (Zip)

Telephone: (305) 638-8050 (Day) _____ (Evening)

Email address: draytonh@usc.edu

Medical School: Keck School of Medicine of USC

Expected graduation: 2025

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: Brandon Mauldy

Signatory's name and title (Please print): Delegation Coordinator State: CA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Karen Restifo, MD SD - Associate Dean Student Affairs

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Email: mss@ama-assn.org

Drayton C. Harvey

4141 Via Marisol, Apt 112, Los Angeles, CA, 90042 / 303-638-8030 /draytonh@usc.edu

Academic Profile

Undergraduate: Dartmouth College, Bachelor of Arts, cum laude - **Major:** Neuroscience **Minor:** Sociology

Graduate: Keck School of Medicine of USC, California Institute of Technology - **Program**: M.D.-Ph.D.

Graduate Thesis Lab: Dr. Ram Kumar Subramanyan

Volunteer/Community Involvement:

ORGANize Dartmouth - Dartmouth College - Co-President - March 2014 – June 2017: ORGANize Dartmouth is a chapter of Donate Life, with a focus on increasing both donor registration and educating the public on organ donation. The group conducts a donor drive during the college's quarterly blood drive, as well as hosts a termly dinner with a guest speaker related to organ donation.

Pre-Health Mentor Corps - Dartmouth College - Co-Director - May 2015 – June 2017: I mentored pre-health students on-campus by keeping in-contact throughout the academic term via email and having lunch with the mentees. I spoke on panels about personal experiences with preparing for medical school and being pre-health at Dartmouth College. I aided students in workshops on planning out which classes to take so they could apply to medical school. I created an event to bring professors and students together to have coffee and discuss aspects other than the professors' work to eliminate barriers between professors and students.

Camp Cardio – Keck SOM of USC – Co-Chair – November 2017 – June 2019: I coordinated and assisted in teaching a week-long summer camp for high school students interested in medicine to educate them about the cardiovascular system and related healthcare professions. During the camp we additionally provided mentorship on applying to college and medical school.

Keck AMA Chapter – Keck SOM of USC – Co-President and Recruitment Chair – May 2017 – June 2019: Since taking on the position I have increased membership at Keck by nearly 300%, successfully obtained a Section Involvement Grant from the AMA, and expanded our executive board from three members to eight. I have additionally fostered relationships with other organizations at Keck including the Health Policy Interest Group, #ProtectOurPatients group, and Physicians for Choice. This inter-group network has gone on to host a social justice mixer, voter registration drive, participated in local marches like the Women's March, and is implementing the AMA's drive to bring health navigators into student run clinics to increase the insured patient population. I also successfully hosted an event for our campus with the president of the California Medical Association where we had an open discussion on the importance of organized medicine, what it means to be a physician-citizen-scientist, and where we go from here in our advocacy as physicians.

AMA-MSS Committee on Legislation and Advocacy – Programming and Special Projects Subcommittees – June 2018 – June 2019: I have planned, coordinated, and implemented programs at Interim 18 and Annual 19 for COLA on grassroots activism and sexual harassment in the healthcare industry. This work included getting guest speakers who have participated in local activism and leaders from the Time's Up Helathcare movement to attend and speak to our members. I have planned and coordinated the new COLA Office Hours every month to increase access of our MSS members to the committee and share the committee members' knowledge with the section.

AMA-MSS Delegate to HOD – Region 1 – November 2018 – November 2019: I have been heavily involved in the resolution review process as one of your delegates, including leading a policy review team and coordinating testimony on behalf of the Region. I have also worked to represent the views of the MSS to the PacWest Caucus and the rest of the House of Delegates.

AMA-MSS Policy Chair – Region 1 – June 2019 – June 2020: I lead the policy discussion for Region 1, ensuring that our region maintains its place as the policy powerhouse of the Medical Student Section. I am working to increase the number of resolutions that come out of our region as well as mentoring the next generation of Region 1 leadership. I guide our members to aid them in crafting polite, powerful testimony so that their opinions and the will of the region are communicated in a way that is both well received and persuasive.

AMA-MSS Committee on Legislation and Advocacy – Chair – June 2019 – June 2020: As chair I oversee the entire committee and aid my vice chairs with management of their subcommittees and resolving obstacles that arise. I instituted three subcommittees as chair to better run the committee and achieve the full breadth of our goals: Legislation, Advocacy, and Policy Development and Education. Projects that the committee has tackled under my leadership include: educational programming on healthcare reform, a report on mandatory reporting of sexual harassment conducted by physicians, building relationships with state medical associations, National Advocacy Week, white papers on healthcare reform bills in Congress, and the creation of a legislative spotlight for medical students. I also run the committee's review of resolutions written by Medical Student Section members related to advocacy and legislation, ensuring that the committee's expertise on such content is given to authors and taken into account by the section at-large.

AMA Resolutions

- **Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents. Annual 2018.**
- **Trauma Informed Care Resources and Settings. Annual 2018.**
- **Increasing Access to Gang-Related Tattoo Removal in Prison and Community Settings. MSS Annual 2019.**

Professional Organization Affiliations

- **American Medical Association -** Keck SOM of USC Co-President 2018-2019, Recruitment Chair 2018-2019, Delegate 2018-2019; Committee on Legislation and Advocacy member 2018-2019; Region 1 Delegate to HOD 2019-2020
- **California Medical Association –** Keck SOM of USC Alternate-Delegate 2017-2018
- **Los Angeles County Medical Association –** Keck SOM of USC liaison 2017-2018
- **American Physician Scientist Association –** Keck SOM of USC Community Outreach Co-Chair and national pre-MD-PhD student mentor 2017-present
- **Dartmouth College Chapter of Sigma Xi Science Honors Society –** Student member

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: MEERA (First) V (Middle) KAPADIA (Last)

Address: 433 W. Remington Dr. (Street address)

City, State, Zip: Chandler (City) AZ (State) 85286 (Zip)

Telephone: 4802821375 (Day) _____ (Evening)

Email address: meera.kapadia@email.arizona.edu

Medical School: University of Arizona College of Medicine – Tucson

Expected graduation: May 2022

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Ronnie Dowling, MD, Chair State: AZ

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print):_____State: _____

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Signature of Dean or Preceptor: George T Fantry MD

Signatory's name and title (Please print): GEORGE T. FANTRY
SENIOR ASSOCIATE DEAN, STUDENT AFFAIRS

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One suitcase and a high school education. That is all my maternal grandfather had moving his family from India to the United States. This diverse, humble background laid the foundation for who I am today. Growing up, it was difficult to see my grandparents struggle with finding the resources to help them alleviate the barriers they were facing—language, medical literacy, distance, income, lack of healthcare, etc. It was eye opening to learn from my peers in school that they were not the only ones facing this situation. As a born and bred Arizonan, the reality of how large our underserved population is was not a foreign concept to any of us.

Additionally, being raised a first-generation Indian-American made it initially difficult to identify with my peers. However, as I matured, I created an identity for myself from both my cultures. This process helped me cultivate an open-minded perspective and better appreciate others' backgrounds as origin, culture, and religion converge to form the distinct identity of individuals. Within medicine, this principle taught me to understand the perspective of and compassionately care for each patient. Moreover, when combined with the reality of the barriers to care in the United States, it encouraged me to advocate for my patients and alleviate their healthcare barriers by connecting them with resources and medical professionals to personalize their treatment. I wanted to utilize my education as a future medical provider to empower others to take charge of their situations.

As an undergraduate student, I was one of the first students to serve as a shift manager and healthcare advocate lead in Phoenix's first free student led clinic, Student Health Outreach for Wellness (SHOW). By becoming the first point-of-contact to all interprofessional providers and students, I was able to see first-hand the type of difference we were able to make to people who had not been able to see providers in over 20 years, refill their medications to manage chronic conditions, receive dental care, or even learn of places that offer free and safe housing for the night. We were able to make a difference in the lives of over 650 patients during the first semester of operation and I was hooked to the impact I could make.

As a medical student at University of Arizona College of Medicine – Tucson, eliminating the barriers to care my patients face is the reason I chose to continue my advocacy work at both a local level—as the Outreach and Fundraising Chair of Shubitz Family Clinic in Tucson, AZ—and at the national level—as the chapter MSS delegate and president to the AMA. Within the scope of the Shubitz Clinic, I have been able to connect our organization to community donors and lead fundraising events that have raised over $7500 for our patients' pap smears, STI screens , lab work, etc. At the national level, I attended my first AMA annual conference the summer before starting my first year of medical school. Since then, I have continued to contribute to removing barriers of care by becoming a co-author my MS1 year on the MSS adopted resolution "Support for Universal Basic Income Pilot Studies" which helped create a conversation regarding how income level directly impacts health status.

Moving medicine forward as a Region 1 Delegate would allow me to continue working towards my goal of making healthcare accessible to all those who need our service. I will do justice to this position through my diverse culture and experiences guided by the education I have received . Since the AMA strives to drive advancement in medicine, I hope to contribute to this cause as an ally to my peers, learn from their perspectives, and work together to both create and determine which solutions best improve patient health.

Meera Kapadia

meerakapadia@email.arizona.edu – (480) 282-1375

Education

University of Arizona College of Medicine – Tucson, Tucson, AZ *Anticipated May 2022*
Doctor of Medicine (MD Candidate, 2022)

- Leadership and Innovation in Healthcare Distinction Track (LIHDT) in progress
- Community Service Distinction Track in progress

Arizona State University (ASU), Tempe, AZ *May 2017*
Ira A. Fulton Schools of Engineering and Barrett, the Honors College
Chemical Engineering (BSE), Summa Cum Laude

Research Experience

Graduate Student Researcher *January 2019 - Present*
University of Arizona College of Medicine – Tucson, Tucson, AZ

- Medical student researcher studying the compliance of frailty assessment within acute surgical care settings on postoperative complications and mortality rates in older adults under PI Dr. Bellal Joseph
- Abstract accepted for oral presentation October 29, 2019 in San Francisco, CA for the American College of Surgeons Clinical Congress

Medical Student Training in Aging Research (MSTAR) *June 2019 – August 2019*
Harvard Medical School, Boston, MA

- Recipient of T35 grant by the National Institutes of Health (NIH) and National Institute on Aging (NIA) to conduct geriatrics research at Beth Israel Deaconess Medical Center and Brigham & Women's Hospital regarding the prognostic implications of cognitive function in functional recovery after transcatheter aortic valve replacement under PI Dr. Dae Hyun Kim

Undergraduate Researcher *January 2014 – June 2018*
Arizona State University, Ira A. Fulton Schools of Engineering, La Belle Group, Tempe, AZ

- Patent and listed inventor for Electroactive Physiological Electrode to be used in glucose sensors under guidance of PI Dr. Jeffrey La Belle
- Honors thesis, "Classification and Application of Electroactive Poly-Amidoamine Polymer (EPOP) for Use in Glucose Sensors." Subject matter includes optimization of EPOP production, characterization of polymer, and validation to produce more accurate and cost-effective glucose sensors

Professional Work Experience

Process Engineer *July 2017 – June 2018*
Intel Corporation, Technology and Manufacturing Group (TMG), Chandler, AZ

- Engineer for the Dielectrics subdivision which manufactures 14 nm and 22 nm microchips in a Fab Class 10 factory
- Responsible for inline production performance of PECVD tools and the deliverables of technicians
- Optimize equipment maintenance, troubleshoot process failures, conduct quality assessment, work with clients ranging across industries to optimize microchip production within a Six Sigma environment and Fortune 500 company
- Active on Next Generation Network board of directors to collaborate on new technology, recruitment and talent acquisition, Intel outreach programs with Arizona schools to encourage STEM education, and Women at Intel Network (WIN) to develop strong leadership skills

Undergraduate Teaching Assistant (UGTA) *January 2017 – May 2017*
Arizona State University, Tempe, AZ

- Provided 130 chemical engineering junior students at ASU the guidance needed to succeed in CHE 433 Modern Separations
- Conducted office hours to answer students' questions and led review sessions before examinations
- Prepared and presented a full lecture once a week on designing industrial separators

Process Engineering Intern *June 2015 – Aug. 2015, May 2016 – Aug. 2016*
Intel Corporation, Technology and Manufacturing Group (TMG), Chandler, AZ

- Built a quality control system using JMP/JSL for the Fab to prevent queue time misses in the wafer production line in Summer 2016
- Monitored new part implementation to ensure goals of upgrades for CVD/LKL/CDO were met (economically and functionally) in Summer 2015

Volunteer Experience

Fundraising and Outreach Coordinator *Oct. 2018 – Present*
Shubitz Family Clinic, Tucson, AZ

- Plan fundraising events such as the annual Cup & Gown Charity Gala, Talent Show, and Annual Bake Sale (over $7500 raised)
- Plan annual Physician Appreciation Dinner for volunteer physicians across Commitment to Underserved People (CUP) clinics
- Run clinic once a month with Student in Charge managing patient charts, appointment schedule, and volunteers
- Contact community organizations to solicit donations
- Collaborate with lab coordinators to maintain medication and supply stock

Medical Student Shadow *Sept. 2018 – Present*
Department of Interventional Radiology at Banner University Medical Center, Tucson, AZ

- Shadow the department of interventional radiology and watch the planning and execution of procedures

Volunteer and Undergraduate Shadow *May 2016 – May 2018*
Emergency Medicine and Surgery at Maricopa Integrated Healthcare System (MIHS), Phoenix, AZ

- Volunteered in the ER at the county hospital
- Shadow to Dr. Kenneth Jackimczyk, emergency medicine and Class 1 trauma, and Dr. Ross Goldberg, surgery, to better understand physician needs in technology and the patients being served

Navigator (Healthcare Advocate) Lead and Shift Manager *Oct. 2014 – May 2018*
Student Health Outreach for Wellness, Phoenix, AZ

- Founding member for the first free interprofessional student-led clinic for the homeless in Phoenix, AZ
- As a clinical manager, led and trained 40 volunteers to cover engineering, medicine, nursing, physical therapy and occupational therapy.
- Treated over 650 homeless patients first semester alone
- Worked in administrative healthcare to understand how healthcare providers procure social resources and resources to care for the underserved population

Counselor *Sept. 2013 – May 2014*
Arizona Mentor Society (AMS), Thew Elementary School, Tempe, AZ

- Tutored children, specifically native Spanish speakers from at-risk communities, in English and math while encouraging STEM education

Organization Involvement

President *Nov. 2018 – Present*
Interventional Radiology Interest Group, Tucson, AZ

- Organize events to better immerse students in the field of interventional radiology including providing guidance about shadowing, research symposiums, and lunch panels to learn about the profession

Student Leadership Team *Oct. 2018 – Present*
Pediatrics Interest Group, Tucson, AZ

- Organize events to better immerse students in the field of pediatrics such as specialty lunch talks to learn about the profession
- Organize events and fundraisers for children at the hospital

Chapter President and National Delegate, Medical Students Section (MSS) *June 2018 - Present*
American Medical Association, Tucson, AZ

- Provided testimony on behalf of Region 1 to the MSS floor regarding MSS resolutions
- Author on policy "Support for Universal Basics Income Pilot Studies" (MSS Adoption Nov. 2018)
- Attended AMA-MSS Annual Meeting (A2018 and A2019)

Application for AMA-MSS Regional Delegate and Alternate- 2020

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Akshara (First) Malla (Last)

Address: 25904 N 50th Ave (Street address)

City, State, Zip: Phoenix (City) AZ (State) 85083 (Zip)

Telephone: 623-256-8243 (Day) 623-256-8243 (Evening)

Email address: aksharam@email.arizona.edu

Medical School: University of Arizona College of Medicine - Phoenix

Expected graduation: 05/2021

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Ronnie Dowling, Delegation Chair State: AZ

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Dr. Susan Kaib, Associate Dean of Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

AKSHARA MALLA

25904 N. 50th Ave, Phoenix, AZ 85083 || aksharam@email.arizona.edu || Cell: (623) 256 - 8243

EDUCATION

University of Arizona College of Medicine – Phoenix
Mel and Enid Zuckerman College of Public Health
M.D. and M.P.H. Candidate, Class of 2021 Expected Graduation: May 2021
Arizona State University, Tempe, AZ
B.S.E. Biomedical Engineering, GPA: 4.0/4.0 Graduated: May 2017
Barrett, The Honors College | Ira A. Fulton School of Engineering

RESEARCH EXPERIENCE

Dr. Shilpa Vellore, Phoenix Children's Hospital, Phoenix, AZ | January 2019—present

- Studying efficacy of right atrium lines in pediatric patients

Dr. Jeffrey LaBelle's Lab, School of Biological and Health Systems Engineering, Tempe, AZ | August 2015—May 2017

- Defended and completed honors thesis project which was to develop a pancreatic cancer multimarker biosensor based on electrochemical impedance spectroscopy technology

Dr. Vinay Nagaraj's Lab, Midwestern University | May 2014—August 2015

- Tested resistance of ovarian cancer cells to taxols and of pancreatic cancer cells to lectin
- Experienced in cell culture, administration of drugs to cells, XTT analysis, electrophoresis

PUBLICATIONS / WRITTEN WORKS

Senior Capstone Project, Co-Author
"Development of an Electrochemical Pancreatic Cancer Sensor," May 2017
Honors Thesis, Co-Author
"Utilization of Electrochemical Impedance Spectroscopy for the Detection of QSOX1 and CEA," April 2017
Poster, Second Author
Akshara Malla, "The development of drug loaded nanoemulsions to overcome Paclitaxel resistance in ovarian carcinoma cells," Osteopathic Medical Conference and Exposition, Sept. 2014.

LEADERSHIP / EXTRACURRICULAR ACTIVITIES

American Medical Association, Medical Student Section (MSS) | January 2018—present

House of Delegates Coordination Committee Co-Chair | July 2019—present

- Coordinate the Medical Student Section's resolution review process and evaluate AMA and MSS policies on their novelty by organizing and leading team calls with committee members

Region 1 Alternate Delegate for the Medical Student Section | November 2018—present

- Advocate for and review health policies written by AMA medical student members while representing Region 1 at the House of Delegates meetings

HOD Reference Committee D Co-Lead | March 2019 – June 2019

Region 1 Policy Review Team Lead | May 2019—present

- Led team calls for Region 1 MSS members and discussed recently authored resolutions for the Annual and Interim 2019 meetings

House of Delegates Coordination Committee member | August 2018—June 2019

- Review resolutions submitted by AMA medical students and provide feedback to authors

UACOM-P Delegate | January 2018—December 2018

- Develop and advocate for health policies to the Medical Student Section on behalf of UACOM-P
- Attended the 2018 AMA Annual Meeting in Chicago and voted on behalf of UACOM-P

Arizona Medical Association | July 2017—present

Medical Student Section Representative to the Committee on Legislation and Government | September 2018—August 2019

Medical Student Section Higher Logic Committee | September 2018—September 2019

Medical Student Section member | November 2018—present
- Advocate for healthcare related legislation during the 2019 legislative session
- Working with other Arizona medical students to create and organize ArMA's reinstated MSS

Wellness Executive Committee | May 2018—May 2019
- Organize and execute events that promote the wellness of medical students at UACOM-P

Cardiovascular Interest Group | December 2017—present
- Organize and execute simulation events and lectures for students interested in cardiology
- Served on the leadership board from December 2017 – December 2018

Pediatric Interest Group | December 2017—present
- Organize and execute lectures and volunteer events for students interested in pediatrics
- Served on the leadership board from December 2017 – December 2018

UA COM – Phoenix Student Ambassador | October 2017—present
- Promote UA COM Phoenix to medical school applicants during interviews and student panels

Student Health Outreach for Wellness | September 2014—present

Medical Student Liaison | December 2017—January 2019
- Perform and obtain vital signs, histories, and physical exams on homeless patients
- Coordinate with S.H.O.W. leadership to organize volunteer opportunities for medical students

Clinical navigator | September 2014—May 2017
- Volunteered at an interdisciplinary clinic for the homeless in downtown Phoenix
- Ushered and checked-in patients and observed patient visits with the physician

Barrett Leadership and Service Team | Spring 2014— May 2017

Secretary & *Barrett Fall Welcome Team* | January 2015—January 2017
- Volunteered at and planned social service events for honors students to raise awareness and money for veterans, cancer patients, low-income children, and others
- Planned and volunteered in the Honor's College's welcome events for incoming freshman

AIDS Advocacy Network—American Medical Students Association | February 2016—May 2017
- Lobbied key advisors of Arizona Senator John McCain for increased PEPFAR funding towards AIDS and TB treatment and research and attended 2017 AMSA conference in Washington D.C.

Barrett—Mayo Premedical Scholars Program | September 2015—August 2016
- Attend lectures, suture clinics, and cadaver dissection labs and shadowed Mayo Clinic physicians

Arizona Mentor Society | August 2014—May 2017
- Tutored 5th grade students in math and reading

ASU March of Dimes | Spring 2014—Spring 2016
- *Vice President,* organized an awareness event to educate 150+ attendees about premature birth

Abrazo Arrowhead Hospital | Summers of 2010-2012, 2014, 2015
- Volunteered in the ED, Surgical ward, PICU, Maternity ward, information desk for 200+ hours

WORK EXPERIENCE

Undergraduate Teaching Assistant | Fall 2016
- Helped BME 100 laboratory (bioengineering course) students learn programs and do assignments

Pinnacle Transplant Technologies | May 2016—August 2016

Research and Development Intern
- Gained experience in cell culture, histology, and viability assays, differentiating bone marrow stem cells, developing new protocols, and created a new decellularized dermal allograft product

Supplemental Instruction Leader | January 2015—May 2015
- Led weekly three-hour review sessions for the students enrolled in the biology course, BIO 181

HONORS/AWARDS

Moeur Award | May 2017
- Awarded for graduating with a 4.0 cumulative GPA while obtaining a B.S.E from A.S.U.

Dean's List | Fall 2013—Spring 2017

Grand Challenge Scholars Program | Fall 2016
- Awarded $1600 research stipend and presented poster detailing work on pancreatic cancer project

Akshara Malla
Diversity Statement Region Delegate/Alternate Delegate 2020

My involvement in health policy stems from my passion to improve the quality of life for my patients and transform the local and national political landscape. My diverse experiences thus far have taught me the importance of advocacy and raising awareness of pertinent issues to eliminate barriers for healthcare and education.

As a clinical volunteer and medical student liaison to the Student Health Outreach for Wellness clinic in downtown Phoenix, I work alongside a multidisciplinary medical team consisting of nurses, physician assistants, physical therapists, and social workers. We provide quality care to the underserved homeless population. By working alongside a multidisciplinary medical team, I understood the complexities of the medical system and the barriers that healthcare patients face in both the medical and socioeconomical elements of healthcare. I quickly became aware of the intricacies of healthcare delivery and the role of each medical professional. Many of my patients were diagnosed with psychological illnesses, faced inconsistent housing arrangements, and suffered many chronic medical conditions. By addressing the role of Medicaid, improving transportation access, and implementing permanent housing solutions, we were able to satisfy the multidimensional needs of our patients.

Furthermore, I served as a clinical volunteer at the Wesley clinic, which is a federally qualified health center based in Phoenix serving the uninsured and underinsured Phoenix population. Treating patients at the Wesley clinic taught me the importance of understanding the psychosocial, financial, and physical needs of my patients. An important lesson I learned early on at the Wesley clinic, is the significance of culture and language on healthcare delivery. Maintaining access to a translator or improving the cultural literacy of health preceptors and professionals ensured that our patients were heard and that their needs were satisfied.

I have and continue to seek awareness of pertinent issues that affect my community's access to resources and education as a third-year medical student on clerkships. Phoenix's diverse population which include Hispanic immigrants and refugees from Africa among many other ethnic and socioeconomic backgrounds, has heightened my awareness of the needs of vulnerable populations and the absolute necessity of affordable access to culturally and medically competent health care. By being a member of the Region 1 delegation, I bring a unique awareness of our patient population's needs and a willingness to learn more about policies that pertain to the socioeconomic needs and hindrances that define our patients' medical care experience.

I chose to pursue a Master's in Public Health concurrently with my M.D. degree to learn about how our medical system and society respond to public health barriers and crises. From my previous experiences in tutoring and as a clinical volunteer, I recognize and value the intersection of the social determinants of health and their outcomes. A thorough understanding of public health has broadened my perspective to look beyond the physical ailments of individual patients. My public health education has trained me to analyze and encourage the implementation of population-based interventions to prevent large-scale medical emergencies and crises. Prior to medical school, I graduated from the Arizona State University with a degree in biomedical engineering – during this time, I interned at a regenerative medicine-based startup and worked as a research assistant in clinical and engineering research labs. My current medical education and my previous undergraduate experiences in combination improved and validated my understanding of the medical device industry and healthcare administration. My insight of these two institutions is valuable for future AMA policies centered on novel and evolving medical technology and its integration in healthcare.

From my invaluable experiences as my medical school's delegate to the AMA Medical Student Section and now Co-Chair of the House of Delegations Coordination Committee, I bring a unique perspective to the AMA Region 1 delegation. I have a strong foundation in policy and advocacy, an enthusiasm to learn more about addressing healthcare needs, and a motivation to improve patients' quality and standard of medical care. As Delegate or Alternate Delegate, I hope to continue to work with new and experienced resolution authors to add to our extensive AMA and MSS policy repository and contribute to the resolution writing process. With these skills, I would like to further contribute to the AMA as a representative of Region 1 and defend the policies that we believe in for the future of our patients.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Natasha (First) Quincey (Middle) McGlaun (Last)

Address: 1775 Evans Ave Apt G-34 (Street address)

City, State, Zip: Reno (City) Nevada (State) 89512 (Zip)

Telephone: 702-810-8802 (Day) _____ (Evening)

Email address: nmcglaun@med.unr.edu

Medical School: University of Nevada Reno School of Medicine

Expected graduation: 2022

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Catherine OMara

Signatory's name and title (Please print): Catherine O'Mara, ED State: NV

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Cherie A. Singer

Signatory's name and title (Please print): Cherie A Singer

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Email: mss@ama-assn.org

Natasha McGlaun

1775 Evans Ave, Apt. G-34
Reno, NV 89512
(702) 810-8802
nmcglaun@med.unr.edu

EDUCATION

M.D., University of Nevada, Reno School of Medicine (UNR Med), Reno, NV — 2022, anticipated
Scholarly Concentration in Medical Education

B.S. in Biology *cum laude*, University of Portland, Portland, OR — 2016
B.A. in Sociology *cum laude*, University of Portland, Portland, OR — 2016

CERTIFICATIONS AND LICENSURES

ACLS — expires 08/2020
BLS — expires 08/2020
Stop the Bleed Instructor Certification

HONORS AND AWARDS

Medical School
N/A

Undergraduate
Dean's List — 2012-2016
President's Scholarship
Four year scholarship awarded on academic merit
Department of Physical and Life Sciences Endowed Scholarship
Bondel Carlton Award
Highest award given to a graduating senior in the department of biology
C. Wright Mills Award for Excellence in Sociology
Highest award given to a graduating senior in the department of sociology

CLINICAL EXPERIENCE

Student Provider, UNR Med Student Outreach Clinic — 2018-Present
Volunteer for 1-2 clinics per month
Preceptorship in Obstetrics and Gynecology with Dr. Hernandez, Reno, NV — 2019
Observed patient interactions and surgeries, 5 hours/week for 9 weeks
Preceptorship in Maternal Fetal Medicine with Dr. Adashek, Las Vegas, NV — 2019
Observed patient interactions and sonography, 40 hours/week for 2 weeks
Preceptorship in Family Medicine with Dr. Magrini, Reno, NV — 2019
Observed patient interactions and took preliminary H&Ps, 3 hours/week for 8 weeks
Emergency Room Scribe, Valley Health System, Las Vegas, NV — 2018
Provided transcription services for team of 10 emergency room physicians, 10 hours/week
Emergency Room Scribe, Kaiser Permanente, Portland, OR — 2012-2018
Provided transcription services for team of 78 emergency room physicians, managed the scribe program, onboarded and trained new scribes, 60 hours/week

TEACHING EXPERIENCE

Tutor for UNR Med's Physician Assistant Program — 2019
Tutored PA students in anatomy and physiology, 2 hours/week
Chemistry Laboratory Teaching Assistant, University of Portland — 2014-2016

TA for general and organic chemistry labs as well as the chemical preparations assistant for all general chemistry labs, 9 hours/week

Biology Laboratory Teaching Assistant, University of Portland 2014-2016
TA for population biology lab, 3 hours/week

Chemistry Tutor, University of Portland 2014-2015
Tutored undergraduates in general and organic chemistry, 3 hours/week

VOLUNTEER EXPERIENCE

UNR Med Delegate, American Medical Association Medical Student Section 2018-Present
Wrote and voted on proposed legislation to the AMA Medical Student Section, 3 hours/week

Member of the HOD Coordination Committee, American Medical Association Medical Student Section 2019-Present
Reviewed policy proposals to the AMA Medical Student Section, 3 hours/week

Leader, Medical Students for Choice Student Interest Group 2019-2020
Hosted various family planning educational events and workshops, 1-2 events/semester

Stop the Bleed Instructor 2019-Present
Participating in training seminars and tabling to teach bleeding control techniques, 1-2 events/semester

RESEARCH EXPERIENCE

Research Assistant, Dr. Kacey Durant, UNR, Department of Family Medicine 2019-Present
Advice Marijuana Dispensaries Give to Pregnant Patrons
Surveyed by phone marijuana dispensaries in the state of Nevada posing as a pregnant patron requesting advice on marijuana use in pregnancy, 3 hours/week

Research Assistant, Dr. Martin Monto, University of Portland, Department of Sociology 2016
Political Correctness, Political Tolerance, and Freedom of Speech: An Analysis of the Characteristics of the Politically Tolerant
Analyzed data from the General Social Survey via Statistical Package for the Social Sciences (SPSS) on evolving trends in political tolerance over time and across various demographic categories, 3 hours/week

Research Assistant, Dr. David Taylor, University of Portland, Department of Biology 2015-2016
Environmental Survey of the Ecological Recovery of the University of Portland River Campus Riparian Zone, Portland, OR: A Comparative Study
Environmental research involving woody plant inventories and health analysis, quadrat sampling of vegetation, netting and quadrat sampling of invertebrate populations, point count surveys of avian populations, and mammal observations, 3 hours/week

PRESENTATIONS

McGlaun, NQ. Political Correctness, Political Tolerance, and Freedom of Speech: An Analysis of the Characteristics of the Politically Tolerant, Presenting author at the Pacific Sociological Association, Oakland, CA. 2016.

McGlaun NQ and Bernard, C. *Environmental Survey of the Ecological Recovery of the University of Portland River Campus Riparian Zone, Portland, OR: A Comparative Study*, Presenting author at the University of Portland Research Symposium, Portland, OR. 2015

PUBLICATIONS

McGlaun N, Marks K, Agrawal N, et al. (2019) *Children of Incarcerated Parents H-60.903*, American Medical Association PolicyFinder, Online.

PROFESSIONAL MEMBERSHIPS

American Medical Association
Stop the Bleed

LANGUAGE SKILLS
English, native fluency

Diversity Statement: I believe I can bring diversity to this position as a non-traditional medical student as I became a first time mom while in medical school. I had my first child, my daughter, during my first year of medical school and have had to navigate the challenges of being a medical student and parent by balancing my studies with family time but I have also had to work through challenges specific to motherhood like being pregnant, giving birth, and expressing milk while keeping up with the intensive preclinical and clinical requirements of medical school. I think these experiences put me in a unique position compared to many other medical students and allow me to help represent the minority of other women in medical school going through similar challenges.

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- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: **Sally** (First) **Midani** (Last)

Address: **8408 Vineyard Ridge Ct NE** (Street address)

City, State, Zip: **Albuquerque** (City) **NM** (State) **87109** (Zip)

Telephone: **(505)730-2383** (Day)

Email address: **midani.sally@gmail.com**

Medical School: **University of New Mexico School of Medicine**

Expected graduation: **May 2022**

AMA-MSS Region (1-7): **1**

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): William L. Ritchie MD State: NM

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Paul McGinn Ph.D. Associate Dean UNM

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Email: mss@ama-assn.org

SALLY MIDANI

Telephone: 505 730 2383
Email: midani.sally@gmail.com - samidani@salud.unm.edu

EDUCATION

University of New Mexico, School of Medicine

Candidate for the degree of Doctor of Medicine, 2022

University of New Mexico

Bachelor of Science in Biochemistry, 2018
Minor in Health, Medicine, and Human Values
Minor in Political Science

Libera Università Internazionale degli Studi Sociali

Attended Summer 2017 program lectured by lawyers, economists, and representatives of the European Union and World Trade Organization in Rome, Italy.

LEADERSHIP

Associated Students of the University of New Mexico

University of New Mexico, 2014-2018

- **Student Body Vice President**, 2018

Presided over body of elected Student Senators and student-government leadership in passage of fiscal legislation, resolutions, and appointments in weekly meetings; student Representative to committees and boards including the University Board of Regents.

- **Lobos for Legislation**, 2016-2018

Student Representative to conglomerate of faculty, staff, administrators, and alumni geared in advocacy efforts for University students at local, state, and national level.

- **Finance Committee Chair**, 2017

Oversaw allocation of over 1 million dollars in student fees to empower undergraduate and graduate student-led initiatives.

- **Elected Student Senator**, 2016
- **Elections Commissioner**, 2014-2015
- **Emerging Lobo Leaders Program,** 2014

American Medical Association - New Mexico Student Chapter

University of New Mexico School of Medicine, 2018-present

- **House Coordination Committee Member**, 2019
- **Co-Vice President**, 2019

Executing membership recruitment, communication-building with New Mexico Medical society, and creating dialogue on national policy.

- **Medical Student Outreach Lead** for the University of New Mexico

Learning Communities Student Representative

University of New Mexico School of Medicine, 2018-present

- **Strategic Planning Committee**

Drafted and passed proposal through faculty for new programming to be implemented annual for MS1 and MS2 classes in 2019-20.

Refugee Service Projects

- **Hikma Health**, 2018-present

Development and translation of workflows for Electronic Medical Records in international refugee communities.

- **Syrian American Medical Society,** 2014-present

Create dialogue on national student committee for projects to assist in refugee crises.

- **TEDxABQ Student Presenter**, 2014

Presented self-produced documentary and spoke on personal experiences with the Syrian uprising.

Global Health Journal Club Officer

AWARDS & HONORS

- Citizenship Award for Outstanding Service to the University of New Mexico and Albuquerque Community, 2018
- Advancing our Community Award Recipient, 2017 & 2018
- Rosalie Furry Doolittle Humanism Award Recipient, 2017
- University of New Mexico Presidential Scholarship, 2014-2018

SALLY MIDANI

Telephone: 505 730 2383
Email: midani.sally@gmail.com - samidani@salud.unm.edu

RESEARCH

Opioid Use Practicum, ongoing

Student lead on multidisciplinary team to improve adherence to State Mandates on Prescription Drug Monitoring Program in inpatient setting at the University of New Mexico Hospital.

Hikma Health, ongoing

Assessing the implementation of app-based Electronic Medical Records in refugee populations including Syria, Lebanon, and Yemen.

Near-Peer Mentorship Project, ongoing

Designing the first instituted school-wide near-peer mentoring program between MS1 and MS3 students at the University of New Mexico School of Medicine.

CLINICAL EXPERIENCES

Border Crisis Asylee Care

Summer 2019

- *Attended to medical needs of asylees transported from detention centers to Medical Reserve Corps facilities.*

Gerald Champion Regional Medical Center

Summers 2012, 2013, 2015, 2019

- *Created a task force on Opioid Safety to disperse educational materials to all hospital departments.*

Practicum: Rural Immersion Experience

University of New Mexico, 2016

- *Rural summer clinical experience in general surgery, anesthesia, and family medicine in Silver City, NM.*
- *Assisted in Hidalgo Medical Services in planning of city-wide community health day with over 20 local businesses and health-geared entities.*

SKILLS

Fluency in Arabic
Limited proficiency in Spanish
Proficient in Robert's Rules of Order
Photoshop and Lightroom graphic design

EMPLOYMENT

Academic Tutor, 2008-2018

Private tutor in Mathematics and Arabic to Albuquerque elementary-high school students.

Gentry Law Firm, 2016

Apprenticeship under attorney designated for representation of minors in mental health institutions; various administrative duties.

Kim Jew Photography, 2014

Trained in Photoshop and Lightroom and served as photography assistant in state-renowned photography company.

VOLUNTEER WORK

- Creating Naloxone Kits with Chicago Recovery Alliance, 2019
- Continuous Quality Improvement: Clinical Reasoning 2 Student Representative, 2019
- Continuous Quality Improvement: Doctoring 3 Student Representative, 2019
- City Drive-Thru Immunization Clinic, 2018
- Patient Triage at Barrett Shelter for Domestic Violence, 2018
- Pediatrics Halloween Carnival for children at University of New Mexico Hospital, 2018
- Reading is Fundamental, 2014-2018
- Children's Miracle Network and LoboTHON Volunteer, 2014-2018
- ASUNM Community Experience student volunteer at community organizations including: Ronald McDonald House, ABQ Biopark, Roadrunner Foodbank, New Day Youth & Family Services.

CONFERENCES

- American Medical Association Annual Meeting, 2019
- American Medical Association Medical Advocacy Regional Conference in Washington, D.C., 2019
- Syrian American Medical Society Conference, 2014-2019
- Hispanic Association of Colleges and Universities Advocacy Conference in Washington, D.C., 2018

Statement of Interest

Traveling back to simpler, less question-bank filled times as an undergraduate at the University of New Mexico, I found myself frustrated at many of the institutional barriers to students seamlessly achieving their academic aspirations. Serving as a part of an elected team in the University of New Mexico's student government association truly underscored the value of the student voice in shaking the status quo—a characteristic undoubtedly core to the way the American Medical Association's Medical Student Section operates. Scribbles on the corner of paper or a light-bulb switched on after a news story turned-policy showed me the strength an idea can carry if channeled through the right outlet, and I am constantly impressed by my peers' ability to do so through AMA.

As an undergraduate, I gained an awareness of campus-wide wants and needs by working hand-in-hand alongside students with interdisciplinary concentrations, keeping in mind diversity of background and thought. Regular meetings with University Legal Counsel taught me the skill of investigating the feasibility of change in consideration of state and national laws. A few trips to the state capitol placed enough pressure to halt the passage of a dangerous bill that sought to drastically increase the financial burden on students to attend in-state University institutions, positively impacting thousands of students and enrollment numbers across a state plagued with immense challenges to our educational system. Mentors and self-proclaimed policy junkies helped me log experience in resolution-writing and policy work, genuinely excited by (including, but not limited to): grammar, attention to detail, research, and preparation required to perfect documents with the power to shift us to a better equilibrium. Serving as an advocate to underserved minority students with lobbyists and leadership from all New Mexico higher-education institutions in Washington, D.C. highlighted the weight of handing a megaphone to individuals previously denied a seat at the decision-making table.

When I offered testimony for the first time at A-19, I transported back to speaking before New Mexico legislators and curating strategy for a student voice in an often recalcitrant Board of Regents. Though some may turn around at the sight of a brick wall, this section of the AMA is known to take on any challenge. I know this to be true because I've been lucky to work with some of the most diligent resolution teams and House of Delegates Coordination Committee members this year. At the end of the day, I could eat, sleep, and breathe work on health policy with an unsatisfied appetite. Thank you all for your consideration, and please do not hesitate to reach out with any questions or concerns.

Sally Midani
samidani@salud.unm.edu
505 730 2383



Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST..
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
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- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Vinita (First) Shivakumar (Last)

Address: 737 Campus Drive, Apt 516 (Street address)

City, State, Zip: Stanford (City) CA (State) 94305 (Zip)

Telephone: 7132991721 (Day)

Email address: vinshiv@stanford.edu

Medical School: Stanford School of Medicine

Expected graduation: 2022

AMA-MSS Region (1-7): 1

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Brandon Marcly

Signatory's name and title (Please print): Brandon Marcly, Delegation Coordinator State: CA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

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Signatory's name and title (Please print):_____State: _____

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Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Neil Gesundheit, Senior Associate Dean for Medical Education

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Email: mss@ama-assn.org



Vinita Shivakumar

Second-year medical student

Email: vinshiv@stanford.edu
Address: 92 Thoburn Court,
Stanford, CA – 94305
Phone: (713) 299-1721

EDUCATION

08/2018 – Present	**Stanford Medical School**, Palo Alto, CA MD Candidate
08/2014 – 05/2018	**Rice University**, Houston, TX B.S. Biochemistry and Cell Biology, Summa Cum Laude

RESEARCH/ WORK EXPERIENCE

05/2019 – Present	**Stanford University**, Palo Alto, CA Research Assistant, Van Haren Lab • Analyzed FACS data from Phase 1 clinical trial on vitamin D in cerebral adrenoleukodystrophy using CytoGenie and FlowJo
05/2019 – 06/2019	**Stanford University**, Palo Alto, CA Teaching Assistant, Advanced Emergency Medicine Summer Camp • Designed curriculum and instructed high school students in medical skills and resuscitation
07/2015 – 04/2018	**MD Anderson**, Houston, TX Research Assistant, Mani Lab • Studied metabolic pathway alterations in metastatic breast cancer using tissue culture, RT-PCR, Western Blot, and other techniques • Presented two posters, working on manuscript for publication
08/2015 – 04/2016 *01/2016 – 04/2016*	**Rice University**, Houston, TX Teaching Assistant, Paradigms of Cell Biology Online Teaching Assistant, Paradigms of Cell Biology • Monitored discussions for massive open online course

	• Graded writing assignments for in-person class
	Rice University, Houston, TX
01/2015 – 04/2015	Research Assistant, Gustin Lab
	• Characterized oral anaerobe interactions with *C. albicans* using spectrophotometry, gel electrophoresis, and other techniques
	Indian Institute of Science, Bangalore, India
05/2013 – 08/2013	Research Assistant, Chakravortty Lab
	• Identified optimal annealing temperature for PCR • Published book review and review article

PUBLICATIONS

Ramirez-Peña, E., Arnold, J., **Shivakumar, V.,** ... Mani, S. A. (2018). The epithelial to mesenchymal transition promotes glutamine independence by suppressing Glutaminase 2. Manuscript submitted for publication.

Shivakumar, V. & Chakravortty, D. (2013). A Slot Machine, A Broken Test Tube. Salvador Edward Luria. [Review of the book *A Slot Machine, A Broken Test Tube] Current Science, 105*(01), 109-110.

Shivakumar, V., & Chakravortty, D. (2014). Biofilms: Community Behaviour in Bacteria. *Resonance, 19*(11), 1005-1016.

LEADERSHIP AND EXTRACURRICULARS

	American Medical Association-Medical Student Section
06/2019 – Present	Secretary, Region 1
	• Managed monthly newsletters, meeting minutes and social media
07/2019 – Present	Member, House of Delegates Coordination Committee
	• Reviewed and gave feedback on resolution ideas and drafts
	Stanford Chapter of AMA-MSS, Palo Alto, CA
01/2019 – Present	Delegate and Vice-President
	• Voting representative in state and national organized medicine for Stanford Medical School
	Stanford APAMSA, Palo Alto, CA
02/2019 – Present	Co-President
09/2018 – 02/2019	Community Outreach Co-Chair
	• Organized internal bonding events for API medical students and external volunteer events focused on API health

Rice Emergency Medical Services, Houston, TX

08/2017 – 04/2018 Duty Crew, Basic EMT

- Certified as Basic EMT, Rice EMS volunteer
- Received award for REMS Most Valuable Newcomer 2018

Rice Chapter of American Red Cross, Houston, TX

08/2017 – 04/2018 Co-President

08/2016 – 04/2017 Vice President

08/2015 – 04/2016 Education Co-Chair and a Founding Member

- Spearheaded chapter's disaster preparedness outreach program – the Pillowcase Project
- Organized fire canvassing, blood draws and other events while growing membership to ~60 general members

Rice Splash, Houston, TX

08/2017 – 04/2018 Internal Vice President

08/2016 – 04/2017 Volunteer Coordinator

- Organized annual education outreach event for low-income middle school students
- Taught lesson plan development to volunteers

School Literacy and Culture, Houston, TX

08-2017 – 04/2018 Intern, Community Bridges Fellowship

- Created online platform for marketing professional development classes for elementary school teachers

Rice University, Houston, TX

08/2015 – 04/2018 Rice Health Advisor, Brown College

- Provided health supplies and peer guidance to members of residential college
- Organized monthly wellbeing events and acted as Wellbeing Office liaison

Rice Student Association, Houston, TX

08/2014 – 04/2015 New Student Representative, Brown College

- Acted as voting representative of residential college in Student Association
- Organized awareness campaign for disability reform

AWARDS

05/2018	**Phi Beta Kappa**, Beta chapter Inducted as member of national honor society
08/2014 – 04/2017	**President's Honor Roll**, Rice University Recognized for outstanding academic achievement in six semesters
03/2015	**Jackie Schnell Memorial Scholarship**, Rice University Recognized for outstanding academic achievement and contribution to residential college
03/2015 *03/2016*	**Donald R. Baker Award**, Rice University Recognized for exemplary academic achievement in Class of 2018 of residential college for two years
08/2014 – 04/2018	**Trustee Distinguished Scholarship**, Rice University Received merit scholarship for research achievements
08/2010 – 05/2014	**National Talent Search Examination Scholarship** Received prestigious national scholarship

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Hank	Matthew	Spellman
	First	Middle	Last
Address:	300 Tijeras Ave NE, Apt 500		
	Street address		
City, State, Zip:	Albuquerque	New Mexico	87102
	City	State	Zip
Telephone:	505-288-9430	505-750-1502	
	Day	Evening	
Email address:	Hmspellman@salud.unm.edu		
Medical School:	University of New Mexico School of Medicine		
Expected graduation:	05/2021		
AMA-MSS Region (1-7):	1		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): G. Randy Marshall, Executive Director State: NM

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Douglas Binder, M.D.

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Email: mss@ama-assn.org

Hank M Spellman

300 Tijeras Avenue North East, Apt 500
Albuquerque, NM 87102
phone: (505) 750-1502
cell: (505) 288-9430
hmspellman@salud.unm.edu

OBJECTIVE

Position as Medical Student Section Regional 1 Delegate.

EDUCATION

University of New Mexico School of Medicine
MD/MBA
2016 – Present
MBA component: Anderson School of Management at the University of New Mexico

University of New Mexico
BS in Biology
May 2014
Minors in Chemistry and Sociology
Focus in teaching and social determinants of suicide prevention and communxy based mental health interventions

Central New Mexico Community College
AA in Liberal Arts
May 2010

Calvary of Albuquerque School of Ministry
AA in Divinity and Church Leadership
May 2004

LEADERSHIP

University of New Mexico American Medical Association Student Group
2019 – Present

President

- Plan and run all business meetings
- Manage the 5-person leadership team to hold monthly events and the resolution writing efforts of those in the state
- Coordinate cooperation between our state medical society and the AMA MSS, including giving monthly updates at our business meetings and speaking at the New Mexico Medical Society monthly meeting

New Mexico Student Medical Society
January 2019 – Present

President

- Serve as a counselor and voting member on the board of the New Mexico Medical Society

- Attend all meeting to represent the University of New Mexico School of Medicine

Ultrasound Medicine Interest Group
July 2017 – August 2018

President
- Advised faculty on the usefulness and student interest in learning ultrasound medicine in the first-year medical training
- Planned quarterly events in our simulation labs to bring ultrasound medicine to MS1 and MSII classes on campus
- Participated in FAST Exam research projects and collected data for student lead research projects

SCHOLARSHIPS AND HONORS

The Washington Campus Scholarship
Summer 2018

Merit based scholarship to attend the one-week Washington Campus Program in Washington, DC. Focused on how to lobby the government to further business and non-profit goals and objectives.

University of New Mexico
May 2014
Honors: cum laude

SERVICE

Big Brother Big Sister
September 2019 – Present

In September, I finished orientation with BBBS of New Mexico and am getting my little brother assigned this month

Health Talk New Mexico
August 2014 – Present

Manage all operations and the website as-well-as visit local schools to discuss health professions and provide information about access to health screenings in their areas. This has included NM and AZ.

New Mexico Medical Society
January 2019 – Present

Serve as a counselor and volunteer on the conference planning committee. This year I will assist in marketing and graphic design for the health conference focused on building interprofessional relationships and education concerning health policies which effect New Mexico.

Health Care for the Homeless
June 2015 – August 2016

Ran check-in and greeted patients for one to two, 4-hour, shifts per month

Peace Corps
July 2015

Served alongside Peace Corps Panama volunteers for 2-weeks to provide youth in the Ngäbe-Buglé Comarca with HIV awareness classes and information about nutrition and domestic violence awareness

EMPLOYMENT

Health Talk NM/HealthTalkNM.org, Albuquerque, NM
August 2014 – Present

Founder, Executive Director

- Manage a 4-person team in developing curriculum for 5th-8th grades encouraging health awareness and health profession careers
- Produce a monthly podcast exploring public health and policy issues in New Mexico and the nation
- Developed and maintain the HealthTalkNM.org site with clear and concise information about medical services available throughout the state.

Alta Mira Specialized Family Services, Albuquerque, NM
August 2014 – June 2016

Substitute Care Provider

- Participated and completed the NM's required training to provide substitute care for a group of adults with various special needs - ranging from Down's Syndrome to Broad-Spectrum Autism.
- Organized, executed, and provided supervision during activities.
- Established group and individual activities based on individual client needs

Nature Pointe Clubhouse Home Owners Association, Tijeras, NM
December 2011 – May 2016

Wedding Coordinator and Event Staff Lead; Independent Contractor

- Managed teams, hiring, and $500k-700k of event sales annually.
- Oversaw coordinating wedding and corporate events and managing all event staff and contractors.
- Established complex timelines with multiple contractors and large groups to provide an exceptional wedding experience.

University of New Mexico, Department of Chemistry, Albuquerque, NM
December 2011 – May 2014

Laboratory Teaching Assistant, General Chemistry I & II

- Taught 48 students per semester, 500+ during my tenure
- Designed curriculum and learning plans with department head
- Responsibilities included grading, time management during class periods, student management and instruction concerning the chemistry topics for each experiment.

University of New Mexico, Title V Grant Office, Albuquerque, NM
August 2011 – December 2011

Peer Learning Facilitator (PLF), General Chemistry I

- Planned and ran in-class activities assigned by professor
- Grading weekly activities submitted by students

- Participated in leadership trainings under Title V and ran advisement programs to help prepare student for graduate school.

T-Mobile USA, Albuquerque, NM
July 2006 – June 2008

Tier IV Customer Care Representative and Team Lead

- My responsibilities included taking technical care calls and resolving issues and concerns while providing would-class customer service.
- Invited to work on focus groups with Blackberry and Windows Mobile for bettering user interface and customer performance and creating new marketing tools for new devices.
- Headed up my work group's one-on-one training program and was trusted with management responsibilities when help was needed.

Solomon's Porch Café, Albuquerque, NM
10/2003 – 7/2006

Head Barista/Assistant Manager, Lead Trainer, and Head Roaster

- Managed all front-ends (cashiers) and baristas (shift managers).
- Programmed register tools and setup pricing, new products and generated basic reports and tracked spending/ordering.
- Set daily activities and trained all new and advancing employees, helped set and build goals, and held team meetings with head manager.

INTERESTS

Health Policy – Since my first AMA MSS meeting, Interim 2017, and subsequent MARC 2018, I have been working to expand my understanding of the workings of health policy. I have since attended every meeting MSS and MARC since and have even taken a year away from medical school to pursue a dual degree, MD/MBA, with a focus in Public Policy

Rock Climbing – 15-years of climbing experience, self-rescue certification, planning an accent of Grand Teton in the Summer of 2020

Hiking – Working towards hiking all 53 14,000ft+ peaks in Colorado and enjoy weekly hikes in the Sandia Mountains in New Mexico

Snowboarding – 18-years of snowboarding has encouraged my enjoyment of the mountains and outdoors

Welding – A recent hobby that allows me to express my artistic side and relieve stress on my breaks between clerkships

DIVERSITY STATEMENT

Before explaining what I will bring to the AMA MSS concerning diversity, I want to share a bit about my conceptualization of diversity; since, each person's perception and understanding of it is slightly different. My favorite quote concerning diversity comes from a rather odd place. Though I believe it describes the very nature of why we must strive for diversity in every organization at every level. The following is an excerpt from The Art of War by Sun Tzu:

> "There are not more than five musical notes, yet the combinations of these five give rise to more melodies than can ever be heard.
>
> There are not more than five primary colours, yet in combination they produce more hues than can ever been seen.
>
> There are not more than five cardinal tastes, yet combinations of them yield more flavours than can ever be tasted."

I believe the same goes for people, backgrounds, and experiences, as Sun Tzu describes for musical notes, primary colours, and cardinal tastes. With a bit of diversity, we can create things which could never have existed without a blending of backgrounds and experiences.

If you have glanced at my CV than you may have noticed that I have quite a diverse background and am a non-traditional medical student. I believe my extensive work history and time working in ministry, missions, and as a counselor gives me a diverse perspective, understanding, and respect for my own heritage and the heritage and culture of others.

I grew up in a rural and medically underserved county in New Mexico. It was already a remote community and on top of that I was homeschooled, so the thought of being a doctor was never presented to me in high school or even in my early years of college. I was also never really exposed to the profession outside of my yearly visits to "Dr. Ma"; she ran the small primary care clinic in Moriarty, New Mexico. I found my path to medicine through my desire to learn about and serve others.

My early exploration of this desire to learn about and serve those around me took me to Mexico, England, Canada, and later Panama to help others in anyway I could. These experiences showed that everyone has something to teach you if you are willing to sit down and learn from them. It was through this understanding that I began my search for a universal way to serve others. The path to answer that question took me many places, from working with other volunteers to build an orphanage in Mexico to volunteering with at-risk youth programs in Harrogate England, but its answer is what has brought me here: medicine and the furthering of meaningful health policy.

I believe my path to medicine is what makes me a diverse candidate and has given me a unique first-hand understanding of the challenges rural and underserved communities face. I hope to bring my understanding and knowledge of caring for those that have the least access to care and some of the most challenging social determinates of health to the MSS. I believe I can contribute a unique perspective to some of the topics and resolutions that affect these populations and help further policy and share first-hand experience with others about what it is like growing up in such a community.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Jonathan	Guan-Lun	You
	First	Middle	Last
Address:	737 Campus Drive, Unit 1213		
	Street address		
City, State, Zip:	Stanford	California	94305
	City	State	Zip
Telephone:	857-256-0996	857-256-0996	
	Day	Evening	
Email address:	jyou1@stanford.edu		
Medical School:	Stanford University School of Medicine		
Expected graduation:	June 2022		
AMA-MSS Region (1-7):	Region 1		

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You

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: Brandon Marchy

Signatory's name and title (Please print): Brandon Marchy, Delegation Coordinator State: CA

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Neil Gesundheit

Signatory's name and title (Please print): Neil Gesundheit, Senior Associate Dean for Medical Education

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Candidate's Diversity Statement: *Please describe how you will bring diversity to the position for which you are applying.*

As an aspiring physician, a gay man, and son of immigrants, I have sought to learn more about and serve diverse marginalized communities. Before medical school, I directed a student-led homeless shelter, led an umbrella organization supporting 80+ student-run service programs, and connected low-income patients to vital social services. Now, as a medical student, I manage the dermatology service for uninsured and underserved patients at the student-led Pacific Free Clinic, and I lead the affinity group for my school's LGBTQ+ medical students.

Having felt unseen or unheard due to my identities has made me a better listener, collaborator, and advocate for inclusivity. Having grown up in a low-income household, I am familiar with the difficult choice between rent and costly medical treatment. Having navigated complex medical terminology in the doctor's office alongside my mother, an ESL immigrant, I appreciate the challenge of gaining health literacy in a second language through my mother's struggles. Having endured bullying and uncomfortable "locker room talk" as an LGBT student of color, I respect the power of inclusive language and visibility. Grounding service in my identity has empowered me to bring my full self to work, enabling me to engage more empathetically with my clients and patients. I wish to serve as a Region Delegate to ensure that these experiences and identities are considered and represented within AMA's policy-making arms.

Additionally, as a second-year medical student and recent first-time AMA annual meeting attendee, I hope to lend a fresh perspective, progressive optimism, and an energetic voice to the Region 1 Delegation of the AMA-MSS, and correspondingly, to serve as a conduit of ideas between my Region, the Medical Student Section, and the Association at large. Thank you for your consideration.

Jonathan G. You
Entering Class of 2018
Stanford University School of Medicine

Jonathan G. You

jyou1@stanford.edu · jonathan.g.you@gmail.com · 857-256-0996 · 737 Campus Drive, Unit 1213, Stanford, CA 94305

Education

STANFORD UNIVERSITY — **Stanford, CA**
Candidate for the degree of Doctor of Medicine. — Expected June 2022

HARVARD UNIVERSITY — **Cambridge, MA**
A.B. in Molecular & Cellular Biology, *magna cum laude* with high honors. — May 2018
Secondary in Economics. Citation in Chinese. | John Harvard Scholar 2015-2016, 2016-2017.
Coursework in Econometrics, Statistics, Health Policy, Corporate Finance, Data Science, Computer Science.

BEIJING LANGUAGE AND CULTURE UNIVERSITY — **Beijing, China**
Summer study abroad coursework in Mandarin Chinese and Chinese culture. — June – August 2015

Service and Health Leadership

AMERICAN MEDICAL ASSOCIATION - MEDICAL STUDENT SECTION — **Chicago, IL**
2019 Interim Meeting – Rules Committee: Member — September 2019 – Present
Review late/emergency resolutions. Support elections oversight. Resolve assembly divisions. Uphold procedural integrity.
House of Delegates Coordinating Committee: Member — July 2019 – Present
Research and review MSS policy. Provide informed recommendations on resolutions at AMA House of Delegates.
Stanford University Chapter: Chair & Alternate Delegate — January 2019 – Present
Initiate all chapter activities, including recruitment, finances, & conference travel. Represent chapter. Review resolutions.
I-19 resolutions in progress: "Enfranchisement of Incarcerated Persons" (1st Author) | "Protecting Immigrant Health and Well-Being" (Co-Author) | "Evidence-Based Practices to Improve Maternal Mortality" (Co-Author) | "Classification and Surveillance of Maternal Mortality" (Co-Author) | "Supporting External Accountability for ICE and CBP" (Co-Author) |"Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections" (Co-Author)

CALIFORNIA MEDICAL ASSOCIATION - MEDICAL STUDENT SECTION — **Sacramento, CA**
CMA Council on Legislation: MSS Nominee for Councilor — May 2019
The medical student endorsed by vote of CMA-MSS executive board to represent the Medical Student Section on CMA's Council on Legislation; confirmation pending approval by CMA Board of Trustees in October 2019.
CALPAC Board of Directors & Executive Committee Liaison — April 2019 – Present
Represent CMA-MSS policy interests to CALPAC Board of Directors. Report key updates to CMA-MSS leadership.
Stanford University Chapter: Chair & Alternate Delegate — January 2019 – Present
Initiate all chapter activities, including recruitment, finances, & conference travel. Represent chapter. Review resolutions.

STANFORD MEDICAL STUDENT ASSOCIATION (SMSA) — **Stanford, CA**
Internal Medicine Interest Group: President — May 2019 – Present
Organize educational & networking events to promote medicine & membership in the American College of Physicians.
LGBTQ-Meds: Co-President — January 2019 – Present
Lead meetings, programming, & outreach. Advocate for LGBT patients & medical students. Respond to current events.
Asian Pacific American Medical Students Association: Advocacy Chair — September 2018 – June 2019
Fostered critical dialogue on AAPI identity. Coordinated language labs with LMSA in Mandarin, Spanish, and ASL.
First-Year Class Representative — September 2018 – June 2019
Represented interests of the first-year class to SMSA. Facilitated first-year social programming. Managed class budget.

STANFORD CARDINAL FREE CLINICS — **Stanford, CA**
Pacific Free Clinic: Dermatology Specialty Clinic Manager — April 2019 – Present
Recruit supervising physicians & student volunteers. Manage appointments & clinic flow. Address patient concerns.

THE JIMMY FUND — **Cambridge, MA**
An Evening with Champions: Executive Co-Chair — January 2017 – January 2018
Led 20-person board. Oversaw organization of annual charity exhibition. Managed strategic partnerships.
An Evening with Champions: Individual Sponsorships Chair — March 2016 – December 2016
Engaged with 2,000 sponsors. Raised $30,000 in individual sponsorships, 50% more than 2015 total ($20,000).

PHILLIPS BROOKS HOUSE ASSOCIATION (PBHA) **Cambridge, MA**
Programming Chair January 2017 – January 2018
Managed strategic teams to improve quality, inclusivity, and value delivery for PBHA's 80+ student-led service programs.

CRIMSON CARE COLLABORATIVE **Somerville, MA**
Clinic at Cambridge Health Alliance: Director of Operations September 2016 – April 2018
Developed & assessed operations protocols. Improved patient experience & care quality. Optimized flow of clinic.

HARVARD SQUARE HOMELESS SHELTER **Cambridge, MA**
Director of Resource Advocacy August 2016 – April 2018
Managed 20+ Resource Advocates. Led weekly meetings with social services providers. Oversaw weekly dinner service.
Overnight Volunteer Supervisor February 2016 – August 2016
Co-supervised 8-10 volunteers during weekly overnight shifts. Coordinated lottery, in-kind donations, and cleanup.
Resource Advocate September 2015 – August 2016
Referred guests to homelessness advocacy and social services resources. Assisted 5+ guests weekly.

Research Experience

STANFORD UNIVERSITY SCHOOL OF MEDICINE **Stanford, CA**
Baker Research Group: Patient Behavior Research Assistant May 2019 – Present
Investigate patient choice of physicians in urban and rural primary care markets with Medicare claims database in Stata.
Stanford Health Consulting Group: Inpatient Digital Health Project Manager March 2019 – Present
Design QI protocol. Interview stakeholders. Synthesize qualitative & quantitative data. Recommend stakeholder action.

HARVARD MEDICAL SCHOOL **Cambridge, MA**
Lesser Lab, Dept. of Microbiology & Immunobiology: SURGH Research Fellow May 2017 – August 2017
Investigated role of ipaH gene family in manipulating human host cell processes during *Shigella flexneri* infection.

HARVARD T. H. CHAN SCHOOL OF PUBLIC HEALTH **Boston, MA**
Essex Lab, Dept. of Immunology & Infectious Diseases: SURGH Research Fellow June 2016 – August 2016
Conducted phylogenetic analyses to understand HIV-1C evolution and transmission patterns in Botswana.

Other Activities and Experience

STANFORD UNIVERSITY SCHOOL OF MEDICINE **Stanford, CA**
Teaching Assistant: Practice of Medicine I September 2019 – Present
Facilitate M1 clinical skills workshops and reviews. Assist creation of curriculum and course materials. Recruit patients.
Teaching Assistant: Leading Value Improvement in Health Care Delivery September 2019 – Present
Coordinate 50-student seminar, including enrollment, communications, room reservation, catering, & faculty scheduling.

HARVARD COLLEGE FUND & HARVARD ALUMNI ASSOCIATION **Cambridge, MA**
Senior Class Committee: House Representative October 2017 – May 2018
Led House's Senior Gift effort. Chaired House Team meetings. Solicited classmates to contribute to Senior Gift.

HARVARD INTERNATIONAL RELATIONS COUNCIL **Cambridge, MA**
Harvard National Model United Nations: Co-Director, UN Development Programme April 2017 – April 2018
Researched, wrote, and edited 70-page background guide. Chaired committee simulation. Managed committee staff.
Harvard National Model United Nations: Director of Business April 2016 – April 2017
Spearheaded expansion of corporate sponsorships; confirmed 5. Developed and executed business strategies.
Harvard Model United Nations: Director of Administration April 2016 – April 2017
Managed conference-wide communications and logistics for 3000+ delegates. Prepared conference materials.

HARVARD UNIVERSITY **Cambridge, MA**
Dept. of Molecular & Cellular Biology, Life Sciences 1a/1b: Course Assistant September 2015 – May 2018
Held weekly office hours. Clarified course material and assignments. Provided informal academic advising.

Skills & Interests

Technical: MS Excel, MS Powerpoint, Python/Jupyter Notebook, Stata, C, HTML, CSS, Mathematica.
Interests: Public service, health policy, global health, teaching, international relations, cultural exchange, cooking.

Dear AMA-MSS Region 1,

I'm writing to humbly ask for your vote to serve as your 2020 AMA-MSS Regional Delegate. As a second-year medical student, I have found my personal and professional home in organized medicine. I'm running for Regional Delegate because I want to serve you as a connector, sounding board, and facilitator, so that together, we may better advance the policy priorities of our AMA-MSS.

To our Region 1 delegation, I'd like to offer my experience in and enthusiasm for health policy and articulate advocacy. In college, my studies of the economics of health, globalization, and finance brought me within one credit of a major in the field. At my university's collegiate Model United Nations conference, I chaired a United Nations Development Programme simulation, where I provided substantive and procedural guidance to a 50-delegate committee, culminating in the adoption of an evidence-based resolution of 93 clauses encompassing climate change, women's empowerment, labor rights, food security, access to care, and pricing of essential medications.

As a medical student, my elective and research interests span the business, law, and economics of innovative, equitable healthcare. Outside the classroom, I serve as my school's AMA-MSS chapter president and alternate delegate, having participated in A-19. At my state medical association, I serve as chapter alternate delegate, represent MSS on my state medical association's PAC, author testimony on behalf of MSS, and was endorsed by the MSS executive board to represent MSS on CMA's Council on Legislation. As an incoming member of the House of Delegates Coordinating Committee, I'm excited to support our AMA-MSS resolution authors and delegates in the coming year. Having actively contributed to policy discussions in college and at the state and national levels in medical school, I'd like to further my involvement in MSS advocacy as your Region 1 Delegate.

Those of you who know me well may know that I gather ample evidence and weigh several perspectives before forming and voicing my opinion on any matter. You can count on me to appreciate the gravity of the role of Delegate and to represent Region 1 with integrity and attention to detail. Likewise, I offer my organizational and leadership skills honed in nonprofit management, fundraising campaigns, medical school affinity groups, and student government. I will work earnestly to facilitate the bidirectional flow of ideas between our Region and our delegation, to engage both our outspoken and reserved peers, to build bridges among the diverse members/chapters of our Region, and to consider the viewpoints of those who may not (yet) have a seat at our table.

In closing, I am determined to amplify the voices of our patients and our student members, so that these voices reach our AMA's largest assembly and our nation's highest legislative chambers. Towards this aim, I humbly invite you to support me as your Regional Delegate. I am endlessly inspired by the clarity and fervor of your advocacy, and I would be thrilled to represent your patient-centered visions of the future at our House of Delegates. Thank you for your consideration.

Sincerely,
Jonathan G. You
Entering Class of 2018
Stanford University School of Medicine

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Kyle (First) S (Middle) Bevers (Last)

Address: 7616 Harwood Ave. Apt. 303 (Street address)

City, State, Zip: Wauwatosa (City) WI (State) 53213 (Zip)

Telephone: 262-224-7580 (Day) ____ (Evening)

Email address: KBevers@mcw.edu

Medical School: Medical College of Wisconsin-Milwaukee

Expected graduation: 2021

AMA-MSS Region (1-7): 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Josha Wetterneck MD, MS

Signatory's name and title (Please print): Tosha Wetterneck State: WI
State Delegation Chair

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print):_____State: _____

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____ MD

Signatory's name and title (Please print): WILLIAM J. HUSTON, MD SR. ASSOCIATE DEAN

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Email: mss@ama-assn.org

Kyle Bevers
8129 Harwood Ave.
Milwaukee, WI 53213
(262) 224-7580
kbevers@mcw.edu

Education

Medical College of Wisconsin, Milwaukee, WI — 2017 - Present
- Doctor of Medicine anticipated May 2021

University of Wisconsin-Madison, Madison, WI — 2006-2010
- Bachelor of Science in Biology with emphasis on Evolutionary Biology

Milwaukee Area Technical College, Milwaukee, WI — 2011
- EMT-B Certification

University of Georgia Center for Continuing Education, Dalton, GA — 2013
- Spanish/English Medical Interpreter Certificate

Medical School Extracurricular Activities

American Medical Association (AMA)
- Co-President - Milwaukee Chapter, Medical College of Wisconsin — 2018-2019
- R2 Resolutions Committee — 2018
- R2 Resolutions Committee Chair — 2019
- Membership, Engagement, & Recruitment Standing Committee Member — 2018-2019
- Committee on Economics and Quality in Medicine Vice Chair — 2018-2019
- AMA Interim 2017 Meeting - Medical Student Section - Attendee — November 2017
- AMA Annual 2018 Meeting - Medical Student Section - Delegate — June 2018
  - Author of Resolution 40 - Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
- AMA Interim 2018 Meeting - Medical Student Section - Delegate — November 2018
  - Served on HCC Convention Committee
- AMA Annual 2019 Meeting - Medical Student Section - Attendee — June 2019

Wisconsin Medical Society
- Wisconsin Medical Society 2018 Annual Meeting – Delegate — April 2018
- Membership Committee Member — 2018-2019
  - Meet throughout the year to discuss current membership and strategies to increase number of members as well as member satisfaction.
- Board of Trustees Student Member — 2020-2021
  - Serve as incoming member throughout 2019-2020 and then will serve my term throughout 2020-2021

Medical Society of Milwaukee County
- Board of Directors – Medical Student Member 2018
    - Meet quarterly to discuss the general operations of the medical society and strategic long-term planning of the Medical Society

Students for a National Health Program
- Founding Co-President – Medical College of Wisconsin Chapter 2018-2019
    - Work with executive board and Physicians for a National Health Program to advocate for a universal health care system in the United States.

Anesthesia Resident Assistant Program
- Resident Assistant 2018-present
    - I spend roughly 12-18 hours monthly assisting anesthesia residents by placing lines, helping OR changeover, and various other tasks to ease the burden on the residents and develop my own skills.

Student Leadership Development Initiative
- Attended meetings and presentations from physician leaders 2018-2019

Research

Medical Student Summer Research Program
- Camara Lab – Anesthesiology Department 2018-present
    - Research was focused on isolating and investigating the causes of the differential behavior of synaptic and nonsynaptic mitochondrial populations from rat brains. This will continue into work investigating the effect mild traumatic brain injuries have on these mitochondrial populations.

- Experimental Biology 2019 April 2019
    - Poster presentations and abstract titles listed below
    - Differences in mitochondrial Ca^{2+} handling during challenges of $CaCl_2$ pulses in brain synaptic and non-synaptic mitochondria: implications for differential Ca^{2+} buffering
        - Kyle Bevers, David Lambert, Keguo Li, Jyotsna Mishra, James Heisner, David Stowe, Wai-Meng Kwok, and Amadou KS Camara
    - K^+ influx triggers slow K^+/H^+ exchange detected by biphasic changes in matrix pH in Guinea pig cardiomyocyte mitochondria
        - David S Lambert, Kyle Bevers, James S Heisner, Amadou KS Camara, Wai-Meng Kwok, and David F Stowe
    - Prevention of mitochondrial pH gradient dissipation: a novel role for cyclosporin A on inhibiting calcium-hydrogen exchange activity in cardiac isolated mitochondria

  - David F Stowe, James S Heisner, Amadou KS Camara, David S Lambert, Lyall Glait, Kyle Bevers, Jyotsna Mishra, and Wai-Meng Kwok

- 9th Annual Medical College of Wisconsin Physician Scientist Student Research Project Presentation Day April 2019
  - Oral presentation of research
  - One of 7 students chosen to present based on abstract submission

- MCW Medical Student Research Day Poster Session October 2018
  - Differences in mitochondrial Ca^{2+} handling during challenges of $CaCl_2$ pulses in brain synaptic and non-synaptic mitochondria: implications for differential Ca^{2+} buffering
  - Dr. Michael J. Dunn Poster Contest Award winner

Employment

Froedtert & Medical College of Wisconsin 2014-2017
- Interpreter, Health Coach

PhysAssist Scribes, Inc. 2013-2014
- Emergency Department Scribe

WorldTeach 2012-2013
- Volunteer English Teacher

Bell Ambulance 2011-2012
- Emergency Medical Technician

Volunteering

Medical College of Wisconsin Student Clinic for the Uninsured
- Volunteered as a student doctor 2017-2018

Pre-Med Pair Up
- Provided guidance to a prospective medical student throughout school 2017-2018

Horizon Hospice
- Friendly visitor Program 2017

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

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- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Zachary (First) R (Middle) Dunton (Last)

Address: 2300 University Ave (Street address)

City, State, Zip: Madison (City) WI (State) 53726 (Zip)

Telephone: 262-893-1594 (Day) 262-893-1594 (Evening)

Email address: zdunton@wisc.edu

Medical School: University of Wisconsin School of Medicine and Public Health

Expected graduation: 2022

AMA-MSS Region (1-7): Region 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: Joshua Wetterneck MD

Signatory's name and title (Please print): Tosha Wetterneck MD State delegation chair State: WI

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Gwen McIntosh

Signatory's name and title (Please print): Gwen McIntosh Associate Dean for Students

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Email: mss@ama-assn.org

Zachary Dunton

2300 University Ave – Madison, WI 53726 – (262)-893-1594 – ZDunton@wisc.edu

Education

University of Wisconsin School of Medicine and Public Health Madison, WI
Doctor of Medicine Anticipated Graduation: June 2022
Master of Public Health
Certificate of Global Health

University of Wisconsin Oshkosh Oshkosh, WI
Bachelor of Science in Chemistry and Psychology Graduation: June 2016
Neuroscience Minor Cumulative GPA: 3.7/4.0
Biomolecular Science and Healthcare Science Emphases University Honors Program

Presentations & Publications

- "Condolences Are Not Enough, We Must Demand Action." Z. Dunton. Cap Times, Madison, WI. September 12, 2019. https://madison.com/ct/opinion/column/zachary-dunton-condolences-are-not-enough-we-must-demand-action/article_d0017044-a22a-50d6-b61b-c7e6824ef3ed.html

- "We Have The Power to End the Gun Violence Cycle." Z. Dunton. Cap Times, Madison, WI. August 14, 2019. https://madison.com/ct/opinion/mailbag/zachary-dunton-we-have-the-power-to-end-the-gun/article_d024e039-8a1d-57e3-89a7-3693ebf2567a.html

- "The Impacts of Repealing the Waiting Period of Handgun Purchases on Suicide." Z. Dunton, S. Hargarten, S. Kohlbeck. Medical College of Wisconsin Injury Prevention Series. July 10, 2019.

- "Structural and Functional Analysis of the Cold-Shock Protein RBM3" Z. Dunton. University of Wisconsin Oshkosh Honors Thesis Symposium in Oshkosh, WI. May 2, 2016.

Leadership

Students for a National Health Program April 2019 – Current
- Drafted a resolution to present to the AMA on neutralizing opinion on single payer
- Collaborated with a multi-organizational national effort on health insurance policy
- Participated in a local healthcare debate between single payer and direct primary care

Chapter Co-President: American Medical Association-MSS January 2019 – Current
- Coordinated an executive effort to connect our students with local legislators
- Facilitated resolution writing and advocacy workshops for our students

State Senate Committee Hearing Testimony August 2019

- Testified in front of the State Senate Committee on Judiciary and Public Safety regarding SB 319: The treatment of a pregnant or postpartum person in prison and county jail

White Coat Boot Camp: Doctors for America June 2019

- Trained in editorial writing, effective legislative conversations, and testimony
- Practiced navigating sensitive topics of suicide, homicide and mass shootings
- Networked with national leaders in gun violence and policy

Region 2 Resolution Committee: American Medical Association. January – June 2019

- Reviewed and evaluated proposed resolutions for regional authorship
- Mentor resolution authors on resolution writing

Reference Committee: Wisconsin Medical Society March – April 2019

- Reviewed and evaluated proposed resolutions submitted to the House of Delegates
- Assessed the value, impact, and scope of proposed resolutions
- Recommended actions to the Wisconsin House of Delegates

Region 2 Conference: American Medical Association Chicago, IL; January 2019

- Received training on resolution writing and advocacy

Conference on Family Planning: Medical Students for Choice Denver, CO; December 2018

- Participated in discussions regarding on gender and reproductive inequities
- Instructed on legal situations surrounding reproductive rights

Interim Assembly: American Medical Association National Harbor, MD; November 2018

- Participated in debate on health policy
- Testified in front of the MSS House of Delegates
- Attended workshops on immigration health at the US-Mexico boarder

Community Involvement

Differential Tuition Finance Committee University of Wisconsin Oshkosh
Chairman, August 2012 – May 2016

- Chaired committee allocating 1.2 million student dollars
- Assessed productivity and purpose of eight campus departments
- Facilitated discussions aimed at improving student resources

Ordinary Heroes Waukesha, WI
Co-Founder, June 2012 – June 2013

- Established a non-for-profit crisis response organization aiding over 200 victims
- Created three philanthropic events to raise over $3,000 supporting victims of tragedies
- Cooperated with 15 local businesses for fiscal support and promotion

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Anna	Siobhan	Heffron
	First	Middle	Last
Address:	402 Grand Avenue, Apt 1		
	Street address		
City, State, Zip:	Madison	WI	53705
	City	State	Zip
Telephone:	402-536-9719	402-536-9719	
	Day	Evening	
Email address:	heffron2@wisc.edu		
Medical School:	University of Wisconsin School of Medicine and Public Health		
Expected graduation:	2022		
AMA-MSS Region (1-7):	Region 2		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: Joshua Weddinedel MD

Signatory's name and title (Please print): Joshua Weddinedel MD State delegation chair State: WI

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Gwen McIntosh

Signatory's name and title (Please print): Gwen McIntosh Associate Dean for Students

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Email: mss@ama-assn.org

Anna Siobhan Heffron

University of Wisconsin School of Medicine and Public Health ● (402)536-9719 ● heffron2@wisc.edu

EDUCATION

University of Wisconsin School of Medicine and Public Health Medical Scientist Training Program (MSTP), Class of 2022
- M.D., School of Medicine and Public Health, anticipated May 2022
- Ph.D., Cellular and Molecular Biology Program, anticipated May 2021

University of Notre Dame, Class of 2014
- B.S. Biochemistry, with minors in Philosophy and Glynn Family Honors Program

RESEARCH

Dr. David O'Connor, Ph.D., Virology, UW-Madison *August 2017 through present*
- Projects: Development of a novel peptide microarray for profiling humoral responses; investigation of protective and pathogenic contributions of humoral responses to Zika virus infections; characterization of microbial translocation during acute HIV infection; characterization of a novel pegivirus in marmosets suffering T cell lymphomas; characterization of other novel viruses

Dr. Xavier Creary, Ph.D., Organic Chemistry, University of Notre Dame *Fall 2011 through May 2014*
- Quantified the stabilizing effects of silylated functional groups on carbocation and carbene intermediates using nuclear magnetic resonance; quantified kinetics of other high-energy reactions

Dr. Dominic Vachon, Ph.D., guided research project, University of Notre Dame *Spring 2013 through May 2014*
- Comparative analysis of elements of Uganda's palliative care program that contribute to its success
- Qualitative research conducted during internship with the Palliative Care Association of Uganda

Dr. Catherine Opere, Ph.D., Pharmacology, Creighton University *May-August 2011*
- Screened a library of compounds using bovine retinae for potential efficacy in treatment of ocular degeneration

LEADERSHIP

University of Wisconsin – Madison
- MSTP Student Executive Board Co-President, *Spring 2019 through present*
- Medical Students for Minority Concerns Secretary and Treasurer, *Spring 2019 through present*
- MSTP Seminar Workshop Committee, *Fall 2017 through present*
- MSTP Outreach and Diversity Chair, *2018-2019 academic year*
- MEDiC Student-Run Free Clinics Clinician Scheduler, *2015-2016 academic year*
- Infectious Diseases Interest Group Student Leader, *2015-2016 academic year*

American Medical Association Medical Student Section
- AMA-MSS Rules Committee Chair, *September 2019 through present*
- AMA-MSS Committee on Global and Public Health Member, *July 2019 through present*
- AMA-MSS Regional Delegate Alternate, *Fall 2018 through present*
- AMA-MSS Membership Chair/Student Outreach Leader for UW SMPH chapter, *2015-2016 academic year*

University of Notre Dame
- Women's Boxing Club Captain and Treasurer, *2013-2014 academic year*
- TA for Appalachia Seminar (250 student lecture and small breakout groups), *Spring 2012 through May 2014*
- Service Commissioner and Environmental Commissioner for residence hall, *2011-2012 academic year*

SERVICE

MEDiC Student-Run Free Clinics, UW SMPH *Fall 2014 through present*
- Provide free medical care to persons who would otherwise be unable to obtain care
- Act as Spanish-speaking interpreter for other students and providers

Mission 4.0 Tutoring *2017-2018 academic year*
- Tutor at Madison West High School for primarily students of color and students from underprivileged backgrounds

Guatemala Global Health Elective, UW SMPH *Spring 2015*
- Raised funds for medical supplies, worked with local hospital and clinics to distribute supplies to patients

Body Donor Ceremony Committee, UW SMPH *Spring 2015*
- Planned and carried out a ceremony for families of people who donated their bodies to the anatomy classes

St. Joseph's Regional Medical Center Emergency Department *Fall 2012 through May 2014*
- Assisted medical personnel, assisted and comforted patients and visitors, cleaned and prepared beds

Center for Social Concerns Service Learning Experiences, University of Notre Dame *Spring 2012 through May 2014*
- Worked with other students and Appalachian residents on home building and repair in rural Appalachia
- Volunteered with and learned from organizations assisting the urban homeless and impoverished in Portland, OR

WORK EXPERIENCE

Resident Assistant, University of Notre Dame *2013-2014 academic year*
- Helped students living in the dormitory, assisted rector with management, and provided guidance to freshmen

Medical Clerk for Goldner Cooper Cotton Sundell Franco Diesing, Neurologists *May through August 2011*
- Organized and prepared patients' charts for physicians, received and made phone calls, bookkeeping

Anna Siobhan Heffron

University of Wisconsin School of Medicine and Public Health ● (402)536-9719 ● heffron2@wisc.edu

EXTRACURRICULAR

Interests: hiking, camping, water sports, long-distance running, reading, yoga, ukulele, playing flute with the Medical Orchestra of the University of Wisconsin, proficient in Spanish

AWARDS AND HONORS

Research funding

- UW Parasitology and Vector Biology Training Grant T32 Award, *September 2019 through present*
- UW Virology Training Grant T32 Award, *September 2018 through August 2019*
- UW Parasitology and Vector Biology Training Program T32 Award, *September 2019 through August 2020*

Travel awards

- Cellular and Molecular Biology Graduate Program Travel Award, *Spring 2019*
- Conference on Retroviruses and Opportunistic Infections New Investigator Scholarship, *Spring 2019*
- Medical Scientist Training Program Travel Award, *Fall 2018*

Other

- Glynn Family Honors, University of Notre Dame, *Spring 2014*
- Honors in Chemistry and Biochemistry, University of Notre Dame, *Spring 2014*
- Cum laude, University of Notre Dame, *Spring 2014*
- Dean's list, University of Notre Dame, *2010-2014*
- Amy Catrow Award for Servant Leadership (Notre Dame Women's Boxing Club), *Fall 2013*

BIBLIOGRAPHY

Peer-reviewed publications:

- **Heffron AS**, Mohr EL, Baker D, Haj AK, Buechler CR, Bailey A, Dudley DM, Newman CM, Mohns MS, Koenig M, Breitbach ME, Rasheed M, Stewart LM, Eickhoff J, Pinapati RS, Beckman E, Li H, Patel J, Tan JC, O'Connor DH. Antibody responses to Zika virus proteins in pregnant and non-pregnant macaques. PLoS Negl Trop Dis. 2018 Nov 27; 12(11): e0006903. PMID: 30481182.
- Buechler CR, Bailey AL, Lauck M, **Heffron A**, Johnson JC, Campos Lawson C, Rogers J, Kuhn JH, O'Connor DH. Genome Sequence of a Novel Kunsagivirus (*Picornaviridae: Kunsagivirus*) from a Wild Baboon (*Papio cynocephalus*). Genome Announc. 2017 May 4;5(18). pii: e00261-17. PMID: 28473378
- Creary X, **Heffron A**, Going G, Prado M. γ-Trimethylsilylcyclobutyl carbocation stabilization. J Org Chem. 2015 Feb 6;80(3):1781-8. PMID: 25562368.
- Creary X, **Heffron A.** γ-Silyl-substituted norbornyl carbocations and carbenes. J Org Chem. 2014 Mar 21;79(6):2547-55. PMID: 24548109.

Non-peer-reviewed publications:

- "Support for Requiring Investigations into Deaths of Children in Foster Care." American Medical Association Compendium 2018-2019. Introduced by **Anna Heffron** and Stephanie Strohbeen at 2018 AMA Interim Meeting.
- **Heffron, A.** "Trust in Training: I Would Rather Not." Acad Med. 2019 May 1;94(5):615. PMID: 30720520
- "Inclusion of Gender Identity and Sexual Orientation in Healthcare Documentation." Wisconsin Medical Society Policy Compendium 2018-2019. Introduced by **Anna Heffron**, Klint Peebles, M.D., and Tosha Wetterneck, M.D. at 2018 WMS House of Delegates meeting.

Invited talks:

- Peter Doherty Institute for Infection and Immunity. November 2018. Profiling antibody responses to Zika virus proteins in macaques.
- UW SMPH Medical Scientist Training Program Annual Retreat. September 2018. Gender and our MSTP.

Abstracts accepted for oral presentation:

- American Society for Virology's 38th Annual Meeting. July 2019. Defining linear B cell epitope cross-reactivity in Zika and dengue virus infections in macaques.
- Annual Wisc-e-Sota Joint UMN-UWI Virology Training Grant Symposium. October 2018. Profiling antibody responses to Zika virus proteins in macaques.
- International Primatological Society Congress. August 2018. High throughput identification of viral exposure histories in nonhuman primates.

Abstracts accepted for poster presentation:

- Annual Wisc-e-Sota Joint UMN-UWI Virology Training Grant Symposium. September 2019. A peptide microarray reliably distinguishes past flaviviral infections.
- Re-Emerging Arboviruses in Global Health Symposium. August 2019. A peptide microarray reliably distinguishes past flaviviral infections.
- American Physician Scientists Association's 15th Annual Meeting. April 2019. Striving for greater gender equity in one MSTP: A framework for stemming the leaky pipeline.
- Conference on Retroviruses and Opportunistic Infections. March 2019. Profiling Antibody Cross-Reactivity Among SIV Isolates Using a Peptide Microarray**.**
- 36th Annual Symposium on Nonhuman Primate Models for AIDS. October 2018. Acute phase SIVmac239 viral load dynamics are similar in male and female Rhesus macaques.
- University of Wisconsin MSTP Annual Symposium. April 2018. Zika Virus Antibody Responses in Non-human Primates.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Titus (First) Hou (Last)

Address: 486 Bienterra Trail Apt. 10 (Street address)

City, State, Zip: Rockford (City) IL (State) 61107 (Zip)

Telephone: 6303861742 (Day) 6303861742 (Evening)

Email address: hou.titus@gmail.com

Medical School: University of Illinois College of Medicine - Rockford

Expected graduation: 2022

AMA-MSS Region (1-7): 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Alexander Levine, CEO State: IL

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Alex Ragnarsdottir, MD, MHPE, MHA

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

Regional Dean

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Titus Hou

Current Address: 486 Bienterra Trail Apt. 10, Rockford, IL
E-mail: thou7@uic.edu **Phone:** (630) 386-1742

Education

The University of Illinois, Rockford, IL
Medical Degree (M.D.) — Expected May 2022
Clinician-Executive Medicine Program

The University of Iowa, Iowa City, IA
B.S. Biochemistry, Honors, *cum laude* — May 2018
Minors: Chemistry, Economics, and Philosophy

Professional Development and Extracurricular Activities

American Medical Association — August 2018-Present
Committee on Long Range Planning; Member — July 2019-Present
Region 2 Committee on Legislative Affairs; Member — January 2019-Present
Parliamentary Procedure Committee Member at Annual Meeting 2019 — June 2019

Illinois State Medical Society — August 2018-Present
Delegate from University of Illinois College of Medicine – Rockford — April 2019-Present
- Attend monthly Medical Student Section meetings to discuss topics relevant to ISMS MSS, engage with other medical student representatives, and draft legislation on behalf of the section

UICOM-Rockford Organized Medicine Interest Group; President — August 2018-Present
- Plan local events to engage with local, state, and national medical organizations to learn about and advocate for various medical policy positions

Winnebago County Medical Society; Student Board Member — August 2018-October 2019
- Attend monthly meetings to discuss medical topics relevant to Winnebago County and provide updates on medical student events at the University

University of Iowa Employment Review Committee; Undergraduate representative — June 2017-May 2018
- Reviewed proposals and hired a firm to review employment practice and policies at the University of Iowa in athletics, academics, and healthcare

University of Iowa Research Council; Undergraduate representative — May 2017-May 2018
- Advised the Vice President of Research and Economic Development on University Research affairs such as fiscal allocation, intellectual property policy, and undergraduate engagement

Association of Big Ten Students; University of Iowa Representative — June 2016-May 2018
- Updated other Big Ten student governments representatives on University of Iowa Student Government's actions on relevant national student issues

University of Iowa Student Government — May 2015-May 2018
Executive Assistant — May 2017-May 2018
- Advised the President and Vice President and helped implement their agenda

Chief Financial Officer — January 2017-May 2017
- Managed $1.8 million in student activity fees for student organizations and student government services

Speaker of the Senate — May 2016-January 2017
- Chaired meetings of 50 members, organized Senators into committees, and prioritized the administration's agenda

Asian American Coalition Constituency Senator — May 2015-March 2016
- Facilitated dialogue between multicultural organizations and student government

Hawkeye Caucus — March 2015-May 2017
- Lobbied state legislators in Des Moines, IA on topics pertaining to higher education

Research Experience

Undergraduate Research Assistant — January 2015-May 2018

Fuentes Lab, Department of Biochemistry, The University of Iowa, Iowa City, IA

Mechanism of Internal Peptide Interaction in Scribble PDZ1

- Designed and created protein domains using PCR and purified protein using FPLC
- Determined protein structure using NMR and X-Ray crystallography
- Performed biochemical assays to determine binding affinity of protein to ligand

Publications

Awadia, S., Huq, F., Arnold, T.R., Goicoechea, S., Sun, Y.J., **Hou, T.**, Kreider-Letterman, G., Massimi, P., Banks, L., Fuentes, E.J., Miller, A.L., and Garcia-Mata, R. (2019) SGEF forms a complex with Scribble and Dlg1 and regulates epithelial junctions and contractility. In Press at *Journal of Cell Biology*.

Posters and Presentations

14th Annual Gene Lata F. Lata Undergraduate Research Symposium — May 2018, Iowa City, IA

Hou, Titus

A Newly Identified Sub-Pocket That Plays a Unique Role in Scribble PDZ1 - SGEF iPBM Interaction

26th Annual Center for Biocatalysis and Bioprocessing Conference — October 2017; Iowa City, IA

Hou, Titus; Sun, Young Joo; Awadia, Sahezeel; Garcia-Mata, Rafael; Fuentes, Ernesto

Defining the Binding Mechanism between the Scribble PDZ1 and an Internal Motif in SGEF

31st annual Gibbs Conference on Biothermodynamics — September 2017; Carbondale, IL

Hou, Titus; Sun, Young Joo; Awadia, Sahezeel; Garcia-Mata, Rafael; Fuentes, Ernesto

Defining the Binding Mechanism between the Scribble PDZ1 and an Internal Motif in SGEF

Fall Undergraduate Research Festival (FURF) — November 2016; Iowa City, IA

Hou, Titus; Sun, Young Joo; Awadia, Sahezeel; Garcia-Mata, Rafael; Fuentes, Ernesto

Defining the Binding Mechanism between the Scribble PDZ1 and an Internal Motif in SGEF

29th annual Gibbs Conference on Biothermodynamics — October 2015; Carbondale, IL

Hou, Titus; Tiwari, Nitija; Sun, Young Joo; Fuentes, Ernesto

Development of a FRET-based System to characterize Protein-Peptide Interactions

Honors, Awards, and Scholarships

- Montgomery Biochemistry Scholar's Prize — 2018
- Rex Montgomery Biochemistry Scholarship — 2017
- Hawkeye Awards: Outstanding Student Organization Leader — 2016-2017
- Distinguished Poster Presentation — FURF 2016
- ICRU Research Fellow — June 2016-August 2016
- Phi Beta Kappa — inducted Spring 2016
- President's List — 2014-2015
- Dean's List — 2014-2018
- UI National Scholars Award, Merit Based — 2014-2018
- UI Old Gold Scholarship, Merit Based — 2014-2018
- UI Tuition Scholarship, Merit Based — 2014-2018
- UI Advantage Iowa, Merit Based — 2014-2018

Volunteer Experience

YMCA Volunteer — May 2019-Present

- Play chess with kids aged 12-17 (20hrs)

Health Care Volunteer, The University of Iowa Hospitals and Clinics, Iowa City, IA

Unit: Burn Treatment Center (75 hours) — June 2016-December 2016

Unit: Respiratory Specialty Care and Comprehensive Unit (106 hours) — June 2015-May 2016

Hobbies and Interests

Playing the cello, running, politics, science fiction

Application for AMA-MSS Regional Delegate and Alternate- 2020

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

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- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Rohan (First) (Middle) Khazanchi (Last)

Address: Apt #304, 608 S 38th Ave (Street address)

City, State, Zip: Omaha (City) NE (State) 68105 (Zip)

Telephone: 402-517-8143 (Day) (Evening)

Email address: r.khazanchi@unmc.edu

Medical School: University of Nebraska Medical Center

Expected graduation: 2021

AMA-MSS Region (1-7): Region 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Amy Reynoldson

Signatory's name and title (Please print): Amy Reynoldson State: NE

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: W Grant

Signatory's name and title (Please print): Wendy Grant, M.D., Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

ROHAN KHAZANCHI

(402) 517-8143
r.khazanchi@unmc.edu

Apt #304, 608 S. 38th Avenue
Omaha, NE 68105

EDUCATION

M.D. University of Nebraska Medical Center, Omaha, NE — 2017 – 2021
Enhanced Medical Education Track: Comprehensive HIV Care

B.A. Washington University in St. Louis, St. Louis, MO — 2013 – 2017
Major: Biology—Neuroscience, *cum laude*
Minors: Psychological & Brain Sciences, Music

HONORS & AWARDS

Finalist, American Medical Association Global Health Challenge — 2018

Dr. Linda B. Ford Medical Education Scholarship, Nebraska Medical Foundation — 2018
- Statewide award for medical student with "outstanding traits of character & leadership" and "strong interest in public health issues"

2nd Place Oral Presentation, Midwest Student Biomedical Research Forum — 2018

Merit Scholarship, UNMC College of Medicine — 2017 - 2020

Harrison D. Stalker Award, WashU Department of Biology — 2017
- Faculty award for graduate who "combines outstanding scientific scholarship with significant contributions in the arts & humanities"

Ethan A. H. Shepley Award, WashU Chancellor Mark S. Wrighton — 2017
- Chancellor's award for "excellence in leadership, scholarship, and service to the campus community"

1st Place Poster Presentation, UNMC SURP Poster Session — 2014

FELLOWSHIPS & GRANTS

UNMC Educational Project Support Grant, UNMC College of Medicine — $3000 — 2019 – 2020

IDWeek Mentorship Program Travel Grant, IDSA Foundation— $500 — 2019

Carolyn L. Kuckein Student Research Fellowship, AΩA Foundation — $5000 — 2018 – 2019

Summer Undergraduate Research Fellowship (BioSURF), WashU Department of Biology — $4000 — 2016

Mary R. Devous Research Award, WashU College of Arts & Sciences — $1600 — 2015

Summer Undergraduate Alcohol Research Program (SUARP), UNMC Department of Internal Medicine — $4000 — 2014

Travel Award, IEEE International Conference on Data Mining (ICDM) — $500 — 2013

ADVOCACY EXPERIENCE

Regional Delegate, *American Medical Association House of Delegates* 2018 – Present

- Elected by medical student section members to represent Region 2 (Nebraska, Minnesota, Wisconsin, Missouri, Iowa, and Illinois) at the AMA HOD
- Led successful caucus efforts to develop major AMA policies, including:
  - H-20.914 - Discrimination and Criminalization Based on HIV Seropositivity

UNMC Section Delegate, *AMA Medical Student Section Assembly* 2017 – Present

- Advocated for policy priorities to federal and state legislators, including GME funding, gun violence research prioritization, and Medicaid expansion
- Mentored and advised UNMC chapter members on resolution writing techniques and key topics in health policy
- Co-authored MSS resolutions to be discussed at upcoming meeting, including:
  - Racism as a Public Health Threat
  - Recognizing Loneliness as a Public Health Issue
- Co-authored several policies adopted by the MSS, to be forwarded for discussion at the upcoming AMA HOD meeting, including:
  - 480.022MSS – Encouraging the Development of Multi-Language, Culturally-Informed Mobile Health Applications
  - 350.020MSS – Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities
  - 295.199MSS –Strengthening Standards for LGBTQ Medical Education
  - 65.028MSS – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented Persons

Co-Founder & Co-Leader, *Nebraska Health Policy Network (HPN)* 2017 – Present

- Cohort program to bring together Nebraska's leading physician-advocates with medical students who want a deeper dive into the "big issues" in health policy
- Organized activities including mock debates on Medicaid expansion & medical marijuana, providing testimony at state legislative hearings, and educational outreach to UNMC community on key legislative issues

Vice President, *UNMC EMPOWER* (website) 2018 – 2019

- Student-led, interprofessional initiative focused on awareness, education, and outreach on gender violence issues
- Hosted lunch meetings and events discussing transgender health, sex trafficking, workplace harassment, and trauma-informed care
- Presented lecture on "#MeToo, Medicine, and Masculinity" to attendees from all five health professions schools at UNMC

Undergraduate Representative, *Washington University Board of Trustees* 2016 – 2017

- Represented 7,500+ undergraduates to the university's highest governing body
- At conclusion of year-long research project, presented funding proposal for sexual violence prevention and mental health initiatives targeted at addressing unmet needs among students of color and LGBTQ students
- Committee service:
  - Board of Trustees committees (prior to quarterly Board meetings): Undergraduate Experience, University Finance, Medical Finance, Educational Policy, Honorary Degree, Buildings & Grounds
  - University committees (monthly): Undergraduate Education committee
  - Search committees (as needed): Associate Vice Chancellor for Student Affairs/Dean of Students, Dean of the Center for Diversity & Inclusion (CDI), University Librarian

RESEARCH EXPERIENCE

Enhanced Medical Education Track (EMET): Comprehensive HIV Care 2018 – Present
University of Nebraska Medical Center, Division of Infectious Diseases
Mentors: Jasmine Marcelin, M.D., Sara Bares, M.D., Susan Swindells, M.B.B.S.

- Comparative cohort study ('97-'07 vs. '07-'17) on impact of race, neighborhood disadvantage, and rurality on HIV disease progression & mortality
- Principal Investigator, IRB #505-18-EP, "Social Determinants of Health Outcomes among People with HIV (PWH) at a Midwest Clinic"
- EMET program also includes longitudinal (i.e. M1-M4) education on interdisciplinary care of PWH through clinical rotations at UNMC HIV Clinic & learning opportunities with community partners

Medical Genetics Student Scholar 2017 – Present
Munroe-Meyer Institute for Genetics & Rehabilitation
Mentor: Lois Starr, M.D.

- First author of two case reports of patients with dysmorphisms, neurodevelopmental delay, and unique genetic variants
- Collaborating with UNMC Neurology faculty on case reports of patients with movement disorders and unique genetic variants

Alpha Omega Alpha (ΑΩΑ) Carolyn L. Kuckein Student Research Fellow 2017 – 2019
University of Nebraska Medical Center, Division of Neonatology
Mentor: Eric Peeples, M.D.

- Cohort analysis evaluating predictive value of ultrasonography to detect various preterm brain injuries
- Principal Investigator, IRB #024-18-EP, "Diagnostic Utility & Timing of Routine Head Ultrasound Screening in Preterm Infants"

Undergraduate Researcher, Dougherty Lab 2015 – 2017
Washington University School of Medicine, Department of Genetics & Department of Psychiatry
Mentors: Joe Dougherty, Ph.D., and Kristina Sakers, Ph.D.

- Neurobiology/neurogenetics research on local translation in astrocytes using *in vivo* mouse models and novel transcriptome profiling methods
- Successfully defended senior honors thesis: "Investigating Localization and Activity-Dependent Translation of Astrocyte mRNA"

Summer Undergraduate Alcohol Research Program (SUARP), Wyatt Lab 2014
University of Nebraska Medical Center, Division of Pulmonary, Critical Care, Sleep, & Allergy
Mentor: Todd Wyatt, Ph.D.

- Pulmonary research using *in vivo* and *in vitro* models to examine effects of cigarette smoke, alcohol, and barn dust on mucociliary clearance and associated secondary messenger systems

Undergraduate Researcher, SEA-PHAGES Phage Hunters Program, 2013 – 2014
Washington University in St. Louis, Department of Biology
Mentors: Sarah Elgin, Ph.D., Kathy Hafer, Ph.D., Chris Shaffer, Ph.D.

- Molecular biology and bioinformatics research isolating, sequencing, and characterizing novel mycobacteriophage species

TEACHING & MENTORSHIP

Principal Investigator, *UNMC Structural Competency Curriculum* 2018 – Present
- First student to receive College of Medicine Education Grant funding, with mentorship from co-investigator Dr. Jasmine Marcelin
- Mission: Create sustainable additions to the College of Medicine curriculum that empower students to meaningfully approach structural determinants of health & local health disparities
- Co-taught lectures on "Intro to Structural Competency" (with Dr. Jennifer Liu) and "Unconscious Bias & Racism in Medicine" (with Dr. Jasmine Marcelin)
- Organized half-day "Structural Competency Workshop", held at an off-campus North Omaha community space, in collaboration with organizations addressing structural determinants in Omaha's underserved neighborhoods

Curriculum Chair, *UNMC College of Medicine Class of '21* 2017 – Present
- Galvanized curricular reform by representing the inaugural class to undergo UNMC COM's new "Training the Physicians of Tomorrow" curriculum
- UNMC committee service:
  - Class of '21 Officers board (2017 – 2021, as needed)
  - Senior Associate Dean's Student Curriculum committee (2017 – 2021, monthly)
  - College of Medicine Curriculum committee (2017 – 2021, monthly)
  - Pre-clinical Block Directors committee (2017 – 2019, monthly)
  - Clinical Clerkship Directors committee (2019 – 2021, monthly)

Volunteer Teaching & Mentorship Activities

Mentor, *UNMC Shadow A Medical Student Program* 2017 – 2019

Mentor, *UNMC High School Alliance* 2017 – 2019
- Mentored local underrepresented minority college & high school students interested in healthcare careers

Lecturer & Mentor, *UNMC Camp Neuro & Camp Cardiac* 2018
- Lectured on social determinants of health, cardiac pathophysiology, and epilepsy/seizures to high school students attending summer camps

COMMUNITY SERVICE

STI Testing & Counseling Specialist, *Nebraska AIDS Project* (website) 2018 – Present
- Volunteered every 3-4 weeks for 3 hours since February 2018
- Anonymous free HIV, gonorrhea, and chlamydia testing and counseling

Patient Navigator, *UNMC Bridge to Care – Refugee Health Fairs* (website) 2018 – Present
- Interdisciplinary student-run organization that seeks to facilitate positive health care outcomes for recently resettled refugees

Volunteer Provider, *SHARING, GOODLIFE, & RESPECT Clinics* (website) 2017 – Present
- Student-run medical, diabetes, and STI clinics (respectively) for underserved and uninsured patients in the greater Omaha area
- 2018-2019: Served as continuity provider for patient at GOODLIFE

PROFESSIONAL ORGANIZATIONS

Member, American Medical Association (AMA) 2017 – Present
Member, Nebraska Medical Association (NMA) 2017 – Present
Member, American Academy of Neurology (AAN) 2017 – Present
Member, Infectious Diseases Society of America (IDSA) 2019 – Present

PEER-REVIEWED PUBLICATIONS

*denotes primary authorship

1. **R Khazanchi***, HR Sayles, SH Bares, S Swindells, JR Marcelin. "Impacts of Neighborhood Deprivation and Rurality on Racial/Ethnic Health Disparities among People with HIV in the U.S. Midwest." Paper (in preparation).

2. D Sapkota*, K Sakers*, Y Liu, AM Lake, **R Khazanchi**, RR Khankan, Y Zhang, JD Dougherty. "Activity-dependent translation in astrocytes." Paper (in preparation for *Glia*).

3. EL Smith*, **R Khazanchi**, KM Cameron, DR Torres-Russotto. "CHRNA7 microduplication in a case of familial myoclonus." Paper (in preparation for *Parkinsonism Relat Disord*).

4. **R Khazanchi***, AT Yetman, JN Sanmann, LJ Starr. **"**First report of *de novo* 12q14.2-q23.3 duplication: patient with multiple congenital anomalies, neurodevelopmental delay, and a connective tissue disorder-like phenotype including cutis laxa." Paper (under review, *Clinical Dysmorphology*).

5. **R Khazanchi***, ER Lyden, ES Peeples. "Re-Evaluating 30-Day Head Ultrasound Screening for Preterm Infants in the Era of Decreasing Periventricular Leukomalacia." Paper (under review, *Pediatric Neurology*).

6. **R Khazanchi***, CA Ronspies, SC Smith, LJ Starr (2019). "Patient with anomalous skin pigmentation expands the phenotype of ARID2 loss-of-function disorder, a SWI/SNF-related intellectual disability." *Am J Med Genet A* 179(5): 808–812. PMID: 30838730.

7. K Sakers*, AM Lake, **R Khazanchi**, R Ouwenga, MJ Vasek, A Dani, JD Dougherty (2017). "Astrocytes locally translate transcripts in their peripheral processes." *Proc Natl Acad Sci* 114(19): 3830-3838. PMID: 28439016.

8. TA Wyatt*, JH Sisson*, **R Khazanchi**, JM DeVasure, PW Cheng, KL Bailey (2017). "Role of PKCε Auto-Down-Regulation in Cigarette Smoke & Alcohol-Induced Airway Cilia Slowing." *Am J Respir Crit Care Med* 195:A2419. Abstract.

9. CL Gerald*, DJ Romberger, JM DeVasure, **R Khazanchi**, AJ Heires, JH Sisson, TA Wyatt (2016). "Alcohol decreases organic dust-stimulated airway epithelial TNF-alpha through a nitric oxide and PKA-mediated inhibition of ADAM-1." *Alcohol Clin Exp Res* 40(2):273-83. PMID: 26842246.

10. WH Pope*, CA Bowman, DA Russell, [et al, including SEA-PHAGES consortium with **R Khazanchi**] (2015). "Whole genome comparison of a large collection of mycobacteriophage reveals a continuum of phage genetic diversity." *eLife* 4: e06416. PMID: 25919952.

11. **R Khazanchi***, K Dempsey, I Thapa, H Ali (2013). "On Identifying and Analyzing Significant Nodes in Protein-Protein Interaction Networks. " *Proceedings of the 13th IEEE International Conference on Data Mining Workshops (ICDMW)*, 343-348. Conference Paper.

ORAL & POSTER PRESENTATIONS

*denotes presenter(s)

1. **R Khazanchi***, D Shaver, A Wheeler, M Beachy. "When Na^+ is N/A: Limitations of Standard Laboratory Testing in Pseudohyponatremia." Poster Presentation at *Nebraska ACP Educational Meeting & Poster Session*. Omaha, NE. October 19, 2019.

2. **R Khazanchi***, HR Sayles, SH Bares, S Swindells, JR Marcelin. "Contemporary Evaluation of Racial/Ethnic Disparities in Survival and Disease Progression among People with HIV in the U.S. Midwest." Poster Presentation at *IDWeek 2019*. Washington, DC. October 4, 2019.

3. **R Khazanchi***, LE Newton*. "Nebraska Health Policy Network: Physician-Student Partnerships in Advocacy." Plenary Presentation at *Nebraska Medical Association (NMA) Annual Meeting*. Lincoln, NE. September 6, 2019.

4. **R Khazanchi***, ER Lyden, ES Peeples. "Re-Evaluating 30-Day Head Ultrasound Screening for Preterm Infants in the Era of Decreasing Periventricular Leukomalacia." Poster Presentation at *17th Pediatric Research Forum*. Children's Hospital & Medical Center, Omaha, NE. May 9, 2019.

5. **R Khazanchi***, ER Lyden, ES Peeples. "Diagnostic Utility of Late Head Ultrasound Screening in Preterm Infants." Poster Presentation at *16th Annual American Medical Association (AMA) Research Symposium.* National Harbor, MD. November 9, 2018.

6. **R Khazanchi***, CA Ronspies, LJ Starr. "ARID2 loss-of-function disorder, a Coffin-Siris-like condition: Eighth reported patient expands the phenotype." Poster Presentation at *16th Pediatric Research Forum*. Children's Hospital & Medical Center, Omaha, NE. May 10, 2018.

7. **R Khazanchi***. "Astrocyte Local Translation is Modulated by Neuronal Activity." Oral Presentation at *49th Midwest Student Biomedical Research Forum*. Omaha, NE. February 17, 2018.

8. **R Khazanchi***, K Sakers, JD Dougherty. "Investigating Localization and Activity-Dependent Translation of Astrocyte mRNA." Poster Presentation at *St. Louis Area Undergraduate Research Symposium (STLAURS)*. St. Louis, MO. April 1, 2017.

9. **R Khazanchi***, K Sakers, J Dougherty. "Investigating Local RNA Translation in Perisynaptic Astrocyte Processes." Poster Presentation at *Washington University Fall Undergraduate Research Symposium*. St. Louis, MO. October 10, 2015.

10. **R Khazanchi***, J Winemiller. "Think Outside the (Music) Box." Oral Presentation at *TEDxWUSTL: Crossroads.* St. Louis, MO. September 16, 2015.
    - View this talk online

11. **R Khazanchi***, JM DeVasure, AJ Heires, J Pavlik, PW Cheng, TA Wyatt. "Role of PKCε Auto-Down-Regulation in Cigarette Smoke & Alcohol-Induced Airway Cilia Slowing." Poster Presentation at *Department of Internal Medicine Poster Session*. University of Nebraska Medical Center, Omaha, NE. August 8, 2014.

12. V Kechejian*, AM Kolasa*, **R Khazanchi**, et al. "Washington University versus the World: Mycobacteriophage Comparisons Drawn on a Local & Global Scale." Poster Presentation at *6th SEA-PHAGES Symposium*. HHMI Janelia Farms Research Campus, Ashburn, VA. June 16, 2014.

13. **R Khazanchi***, AM Kolasa, ES De Togni, and JA Nahon. "Isolation & Characterization of the Novel Mycobacteriophage Gaius." Poster Presentation at *Washington University Spring Undergraduate Research Symposium*. St. Louis, MO. April 28, 2014.

14. **R Khazanchi***, K Dempsey, I Thapa, H Ali. "On Identifying and Analyzing Significant Nodes in Protein-Protein Interaction Networks." Oral Presentation at *3rd IEEE ICDM Workshop on Data Mining in Networks (DaMNet).* Dallas, TX. December 7, 2013.

Application for AMA-MSS Regional Delegate and Alternate- 2020

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ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Raj (First) Anirudh (Middle) Kumar (Last)

Address: 1922 Bradley Road (Street address)

City, State, Zip: Rockford, (City) IL (State) 61107 (Zip)

Telephone: (352) 220-4612 (Day) (Evening)

Email address: rkumar28@uic.edu

Medical School: University of Illinois - Rockford

Expected graduation: 2021

AMA-MSS Region (1-7): 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Alexander Lerner, CEO State: IL

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Alex Stapnas-Gilden, MD MHPE, MMM
Regional Dean

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Raj A. Kumar

Education

MD Candidate — May 2021 (expected)
University of Illinois at Chicago – Rockford Campus

Bachelor of Science Degree in Neuroscience and Biochemistry — May 2017
Minor in Microbiology
Cum Laude
University of Minnesota, Minneapolis, Minnesota

Leadership

Vice Chair for Reference Committee of the AMA Medical Students Section — November 2019

Vice Chair for Region 2 of the AMA – Medical Students Section — June 2019 – June 2020
American Medical Association – Medical Students Section

Chair-Elect for ISMS – Medical Students Section — April 2019 – April 2020
Illinois State Medical Society – Medical Students Section

Medical Student Trustee for the Illinois State Medical Society — April 2019 – April 2020
Illinois State Medical Society – Medical Students Section

Reference Committee Member for the AMA – Medical Students Section — June 2019

Secretary for Region 2 of the AMA – Medical Students Section — June 2018 – June 2019
American Medical Association – Medical Students Section

Committee on Scientific Issues – Symposium Subcommittee Chair — June 2018 – June 2020
American Medical Association – Medical Students Section
(Appointed two consecutive years)

President of Organized Medicine Interest Group — April 2018 – April 2019
University of Illinois College of Medicine - Rockford

Member of the Learning Environment Advisory Group, Student Council — August 2017 – August 2018
University of Illinois College of Medicine - Rockford

Director of Committee for Campus Life, Student Government — April 2016 – April 2017
University of Minnesota

Founder of HealthSync (Start-up Company) — February 2016

- HealthSync is a start-up company to increase healthcare outreach to rural India
- Recognized and funded by the University of Minnesota

Crisis Counselor at The Aurora Center for Advocacy and Education February 2016 – May 2017
University of Minnesota

- Certified crisis counselor for survivors of sexual assault, relationship violence, and stalking by the state of Minnesota (Statute 595.02, subsection k)

Elected At-Large Representative of the Student Body to Student Government September 2015 – May 2017
University of Minnesota

Research

Bench Research

Honors Thesis Research at the Stem Cell Institute, University of Minnesota May 2016 – May 2017

Research Volunteer at University of Central Florida May 2014 – May 2015

Research Intern at Cleveland Clinic Center for Reproductive Medicine Summer 2012

Writing and Presentations

Predictors of Transrectal Ultrasound-Guided Prostate Biopsy Complications

- **Kumar, R.**, Abern, M., Andriole, G., Freedland, S. & Moreira, D.
- Podium presentation at North Central Section of the American Urological Association, September 2019

Left Kidney Within a Large Left Inguinal Hernia

- **Kumar, R.**, Desai, P., Iyer, H. & Moreira, D. Left Kidney Within a Large Left Inguinal Hernia. *Urology* 128, 5-7 (2019).
- PMID: 30796992

Treatment of Hypogonadal Men with Clomiphene Citrate Does Not Significantly Increase the Risk of Polycythemia: A Multi-institutional Study

- Wheeler, K., Smith, R., **Kumar, R**., Setia, S., Costabile, R. & Kavoussi, P. A Comparison of Secondary Polycythemia in Hypogonadal Men Treated with Clomiphene Citrate versus Testosterone Replacement: A Multi-Institutional Study. *Journal of Urology* 197, 1127-1131 (2017).
- PMID: 27984109

Epigenetics Application in the Diagnosis and Treatment of Bladder Cancer

- Harb-de la Rosa, A., Acker, M., **Kumar, R.** & Manoharan, M. Epigenetics application in the diagnosis and treatment of bladder cancer. *Canadian Journal of Urology* 22, 7947-51 (2015).
- PMID: 26432963

Novel Bio-Wrap Assisted Vasectomy Reversal Technique

- Gudeloglu, A., Brahmbhatt, J., **Kumar, R.** & Parekattil, S. Novel Bio-Wrap Assisted Vasectomy Reversal Technique. *Journal of Urology* 191, (2014).

Clinical Reproductive Medicine and Surgery: A Practical Guide.

- **"Female and Male Gametogenesis" Textbook Chapter**
  - 2nd Edition (pages 43-62)
    - Clinical Reproductive Medicine and Surgery: A Practical Guide. (Springer International PU, 2013).
  - 3rd Edition (pages 19-46)
    - Clinical Reproductive Medicine and Surgery: A Practical Guide. (Springer International PU, 2018)

AMA-MSS Regional Delegate Application – Candidate Diversity Statement

First and foremost, I want to acknowledge that men and folks of South Asian ethnic origin are currently not at all underrepresented in the U.S. medical system, nor will I face the same challenges as my ethnic/gender minority colleagues in this regard. With that said, I think there are a few other ways in which I intend to center diversity, inclusion, and equity in my work as an AMA-MSS Regional Delegate.

As a student at the University of Nebraska Medical Center, I attend an institution that has the difficult task of training providers to address the needs of both rural and urban Nebraskan communities. This presents unique challenges that have been discussed throughout my training, ranging from access to care for patients living hours away from major rural health centers to health disparities facing minority and refugee patients living in the deeply segregated, systemically oppressed neighborhoods of urban Omaha. In this regard, my being a citizen of Omaha, student at UNMC, and advocate for the patients of Nebraska position me uniquely to understand and synthesize issues facing a widely ranging patient population.

My undergraduate training at Washington University in St. Louis from 2013-2017 was the foundation of this perspective—living just 10-15 minutes away from Ferguson during the events following the 2014 shooting of Michael Brown stimulated my lasting interest in health equity, racial justice, and applying a radical framework to health disparities research. These interests in health equity led directly to my work at UNMC, where I am currently conducting a longitudinal research project evaluating neighborhood-level disparities in outcomes among persons living with HIV and have given presentations on topics like "#MeToo, Masculinity, and Medicine" as an advocate for gender equity in medicine with the UNMC EMPOWER group.

While my lived experiences of facing marginalization because of my identity are infrequent relative to, for example, my LGBTQ or under-represented minority colleagues, I hope to bring diversity to this position by lending my voice in support of the patients and colleagues who need our advocacy most and who have historically been helped least. My primary focus will remain as such throughout my time in the AMA, as I look forward to continuing my trajectory as an advocate for equity and justice.

Thank you for your consideration,



Rohan Khazanchi
University of Nebraska Medical Center '21
r.khazanchi@unmc.edu

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

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- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Thomas (First) Kun (Middle) Pak (Last)

Address: 339 teeters court (Street address)

City, State, Zip: Iowa City (City) Iowa (State) 52246 (Zip)

Telephone: 515-865-1662 (Day) 515-865-1662 (Evening)

Email address: tpak.jhu@gmail.com / thomas-pak@uiowa.edu

Medical School: Carver College of Medicine (Iowa)

Expected graduation: 05/22

AMA-MSS Region (1-7): Region 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Mike Flesher

Signatory's name and title (Please print): Michael Flesher State: IA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor:

Signatory's name and title (Please print): Christopher S. Cooper - Sr. Associate Dean for Med Ed.

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Thomas K. Pak **University of Iowa Carver College of Medicine UI ID#: 00817435**
14100 Pinnacle Pointe Unit 302, Clive IA, 50325 (515) 865-1662 thomas-pak@uiowa.edu

EDUCATION

IOWA CARVER COLLEGE OF MEDICINE, Iowa City, IA
Medical Student Training Program (MD/PhD Student), Class of 2022

JOHNS HOPKINS UNIVERSITY, Baltimore, MD
Bachelors of Arts Neuroscience May 2012, Minor in Bioethics May 2012,
~ Certificate in Dance, May 2012

ACADEMIC AND ATHLETIC ACTIVITIES

AMERICAN MEDICAL ASSOCIATION	
MSS Region 2 Board Member	June 2019-Present
MSS Committee on Long Range Planning	Jan 2019-Present
HOD Delegate Convention Committee	Interim 2018
Region 2 Resolutions Committee	Interim 2018
GPSG OF UNIVERSITY OF IOWA (**vice-president**)	May 2018-Present
Graduate and Professional Student Government	
AMA-IMS CHAPTER AT CCOM (**president**)	May 2018-Present
IOWA MEDICAL INNOVATIONS GROUPS	Sept 2016-May 2017
IOWA MEDICAL SCHOOL ADMISSIONS COMMITTEE (**student rep**)	June 2015- June 2017
IOWA MEDICAL STUDENT RESEARCH CLUB (**officer, co-president**)	May 2014- May 2016
STUDENT INTEREST GROUP IN PSYCHIATRY (**co-director**)	May 2014- Present
STUDENT INTEREST GROUP IN NEUROLOGY (**officer, co-president**)	Aug 2013- Present
JHU BALLROOM & DANCESPORT TEAM (**president**)	2010- 2012
UNDERGRADUATE BIOETHICS SOCIETY (**office**r)	2010 - 2012

VOLUNTEER ACTIVITIES

ALPHA KAPPA KAPPA - LOCAL CHAPTER (**co-president**) June 2015- Present
• run a medical fraternity house addressing finances, maintenance, and social events
HOWARD HUGHES MEDICAL INSTITUE (**Midwest regional co-chair**) June 2015-June 2017
• direct and coordinate the Midwest regional and National events for HHMI medical fellows
INTEL SCIENCE FAIR (volunteer and judge) Aug 2013- June 2017
• Help organize and run science fair events at regional, state, and international level
FREE MENTAL HEALTH CLINIC Aug 2013- June 2017
• take medical histories and interact with patients with mental health concerns
BALTIMORE RESCUE MISSION CLINIC (volunteer) Jan 2012-Aug 2013
• take medical histories, diagnose illnesses, and interact and communicate with patients under doctor supervision at a homeless shelter; teach students to take patient history and vitals

ACADEMIC AND PERFORMANCE AWARDS

UNIVERSITY OF IOWA	
Distinguished Student Leader Award (two graduate students awarded)	2018
INTEL INTERNATIONAL SCIENCE AND ENGINEERING FAIR	
Grand Awards Judge (one of the youngest judges at ISEF)	2016

Thomas K. Pak **University of Iowa Carver College of Medicine UI ID#: 00817435**
14100 Pinnacle Pointe Unit 302, Clive IA, 50325 (515) 865-1662 thomas-pak@uiowa.edu

CARVER COLLEGE OF MEDICINE
Mr. Iowa winner (Medical School Talent Show) 2014
OFFICE OF STUDENT ACTIVITIES (JHU)
Outstanding Student Organization President Award 2011
BALLROOM COMPETITION AWARDS
USA Dance Nationals (4th in silver standard, 3rd in bronze standard) 2011
PRESIDENT'S COUNCIL ON SERVICE AND CIVIC PARTICIPATION
The President's Call to Service Award 2008
INTEL INTERNATIONAL SCIENCE AND ENGINEERING FAIR
Team Finalist (leader of the team project) 2006

FUNDING AWARDS

GRADUATE COLLEGE
Post-Comprehensive Research Fellowship [$9,500] 2019
GRADUATE COLLEGE
Summer Research Fellowship [$4,500] 2019
GRADUATE AND PROFESSIONAL STUDENT GOVERNMENT
Research grant [$1,000 grant] 2018
HOWARD HUGHES MEDICAL INSTITUTE
Renewal of Medical Fellowship (13 renewals given that year) [$41,000 grant] 2016
AMERICAN ACADEMY OF NEUROLOGY
Medical student travel award to the AAN meeting (Declined for HHMI) [$1,000] 2015
HOWARD HUGHES MEDICAL INSTITUTE
Year-long Medical Fellow (68 awards given nationally) [$41,000 grant] 2015
HOWARD HUGHES MEDICAL INSTITUTE
Summer Medical Fellow (37 awards given nationally) [$5,000 grant] 2014
IOWA MEDICAL STUDENT RESEARCH PROGRAM
Summer Research Fellow (Declined for HHMI) [$5,000 grant] 2014
OFFICE OF PROVOST (JHU)
Provost Undergraduate Research Award [$2,500 grant] 2010

ARTICLE AND CHAPTER PUBLICATIONS:

1. **[opinion news article] Pak, T.,** Siddiqui, N. (2019) Medical school students: Detained migrants still have a right to proper medical care. *USA Today*.
2. **[review article]** Weihbrecht, K., Goar, W., **Pak, T**., et al (2017). Keeping an Eye on Bardet-Biedl Syndrome: A Comprehensive Review of the Role of Bardet-Biedl Syndrome Genes in the Eye. *Medical Research Archives.* 5(9) sep. 2017. ISSN 2375-1924.
3. **[book chapter]** Blackshaw, S., Lee, D. A., **Pak, T.**, & Yoo, S. (2016). Regulation of Body Weight and Metabolism by Tanycyte-Derived Neurogenesis in Young Adult Mice. *Stem Cells in Neuroendocrinology* (pp. 51-67).
4. **[newsletter] Pak T,** Cychosz C (2014). Importance of physicians conducting research. American Physician Scientist Association National Newsletter.
5. **[research article]** Lee D*, Yoo S*, **Pak T***, Salvatierra J, Aja S, Velarde E, Velarde E and Blackshaw S (2014). Dietary and sex-specific factors regulate hypothalamic neurogenesis in young adult mice. *Frontiers Neuroscience.* 8:157.
6. **[research article] Pak T***, Yoo S*, Miranda-Angulo AM*, Wang H, Blackshaw S (2014). Rax-CreERT2 knock-in mice: a tool for selective and conditional gene deletion in progenitors and radial glia of the retina and hypothalamus. *PLoS ONE* 9(4): e90381.
7. **[research article]** Lee DA, Bedont JL*, **Pak T***, Wang H, Song J, et al (2012). Tanycytes of the hypothalamic median eminence form a diet-responsive neurogenic niche. *Nature Neuroscience* 15: 700-702.
8. **[research article]** Rossetti F, de Araujo Furtado M, **Pak T**, Bailey K, Shields M, et al (2012). Combined diazepam and HDAC inhibitor treatment protects against seizures and neuronal damage caused by soman exposure. *Neurotoxicology* 33: 500-511

Candidate's Diversity Statement

Thomas Pak

I understand that I do not represent underrepresented demographics. I do have diverse experiences, from growing up in Iowa, to experiences as a second-generation Korean American, to being raised in a low socioeconomic background. From these experiences, I can provide a different perspective to my fellow student delegates.

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- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Abigail (First) Emily (Middle) Solom (Last)

Address: 3620 Trenton Ln. N. (Street address)

City, State, Zip: Plymouth (City) MN (State) 55441 (Zip)

Telephone: 763-486-2234 (Day) same (Evening)

Email address: solom110@umn.edu

Medical School: University of Minnesota - Twin Cities

Expected graduation: 2021

AMA-MSS Region (1-7): 2

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: Janet Silversmith

Signatory's name and title (Please print): Janet Silversmith, CEO State: MN

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print):_____State: _____

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: 

Signatory's name and title (Please print): Anne G. Pereira, MD, MPH, FACP, Assistant Dean for Curriculum

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Email: mss@ama-assn.org

ABBY SOLOM

solom110@umn.edu • (763) 486-2234
3620 Trenton Ln. N. • Plymouth, MN 55441

Education

University of Minnesota School of Medicine and Carlson School of Management
Doctor of Medicine — Anticipated Spring 2021
Master of Business Administration

University of Wisconsin-Madison
B.S. Natural Sciences — May 2012
Microbiology major, certificate in Global Health
Graduated with honors

Career Goal

Harness the power of prevention to innovate more effective models of primary care, resulting in better outcomes and a more affordable and just healthcare system.

Professional Leadership

Minnesota Medical Association Medical Student Section Executive Board
Trustee — Sept 2018 – Present
Represent interests of students to the Board of Trustees
Serve as public-facing

American Medical Association – University of MN Twin Cities Chapter
Regional Delegate — Nov 2018 - Present
State Delegate — Dec 2016 – Dec 2018

- Analyze and vote on policy to support advocacy and represent students of MN and the Midwest
- Develop creative communication strategies to support student advocacy and political activism

Health Promotion Experience

University of Minnesota Medical School Wellbeing Committee
President — June 2017 – June 2018

- Built wellness programming for 500 students at U of M
- Incorporated components of all aspects of wellbeing
- Developed innovative incentive program to encourage and reward self-care

Minnesota State Academy for the Deaf
Volunteer — Jan – May 2019

- Delivered nutrition and cooking classes for residential youth at MSAD
- Designed curriculum with knowledge and practical skills applicable to independent living, with a focus on eating to prevent chronic disease

Lifetime Fitness Corporation
Group Fitness Instructor — March 2016 – Present

- Plan and deliver high quality group fitness class for members of all ages
- Teach cycle, strength training, and high intensity interval training formats
- Certified by American Council on Exercise, additional certifications from Schwinn cycle and Road Runners Coaches of America

HealthFitness Corporation
Lead, Health Coaching and Advising June 2014 – July 2016

- 20 hours/wk 1:1 coaching in weight loss, stress management and tobacco cessation
- 20 hours/wk staff support for team of 100; perform staff evaluations and staff training
- Client onboarding; interdepartmental support for quality improvement, marketing, sales, and product management

Health Advisor March 2013 – June 2014

- Engage participants in discussions about their health; educate them on biometric data, risk factors, and chronic condition
- Encourage them to pursue their health goals through strategies for healthy living; connect them with programs and referrals to best support them

Cheerful Hearts Foundation and UBELONG October 2012 – March 2013
Accra, Ghana
Public Health Educator

- Designed and ran workshops on disease prevention and health promotion
- Designed program to train local teachers on disease prevention topics
- Conducted research project to assess health information communication in rural Ghana

Department of Public Health of Madison and Dane County Spring 2012
Acute Communicable Diseases Intern

- Conducted follow-up interviews with patients with confirmed cases of foodborne illness
- Educated patients, empowering them to prevent disease spread and future illness
- Kept food history and symptom data for epidemiological tracking and outbreak prevention

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Academic Research Experience

M Health Quality Improvement Collaborative 2017
Minneapolis, MN
Research Assistant

- Designed and revised protocols to encourage mindfulness practices with psych floor staff
- Collected and analyzed data on intervention efficacy and provided recommendations for improvement

International Collaboration on Participatory Health Research Summer 2012
Alberta, Canada
Research Intern

- Planned and conducted pilot study on the uses of Participatory Action Research in Health
- Performed data collection and literature review; wrote protocol and IRB application
- Gave recommendations for repeating my study on global level

University of Wisconsin Department of Bacteriology 2009 – 2011
Madison, WI
Undergraduate Researcher

- Independent research project performing qPCR on cyanobacterial samples
- Analyzed and managed large data set to learn about environmental drivers of toxicity

Presentations

AAMC Joint Committee for Groups in Student and Resident Affairs — April 2018
Incentives in Medical School Wellbeing: Innovative, Behavior-Based Design of Medical School Wellbeing Programs

Quality Improvement Symposium, University of Minnesota Medical School — January 2018
Reducing Restraint and Seclusion on Child/Adolescent Psychiatric ITC

Research Symposium Poster, University of Minnesota — April 2010
Identifying Drivers of Microcystis Bloom Dynamics and Cyanotoxin Potential in Lake Mendota

Additional Languages

American Sign Language (proficient/conversational)

Hobbies, Interests and Activities

Teaching cycling and group fitness classes
Competition dance team member
Half-ironman triathlons

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Sneha (First) Ramesh (Middle) Aidasani (Last)

Address: 5503 Research Drive Apt. 1212 (Street address)

City, State, Zip: San Antonio (City) Texas (State) 78240 (Zip)

Telephone: 212-729-4985 (Day)

Email address: aidasani@student.uiwtx.edu

Medical School: University of the Incarnate Word School of Osteopathic Medicine

Expected graduation: 05/2021

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: David Henkes MD

Signatory's name and title (Please print): David N. Henkes, MD, Chair, TX Delegation State: TX

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Robyn Phillips-Madson, DO

Signatory's name and title (Please print): ~~Robyn Phillips-Madson, DO, Dean UIWSOM~~

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Sneha Aidasani

212-729-4985 · aidasani@student.uiwtx.edu

Education

University of the Incarnate Word School of Osteopathic Medicine– San Antonio, TX
D.O. Candidate, May 2021

Columbia University Medical Center, College of Physicians and Surgeons – New York, NY
Institute of Human Nutrition
MS in Nutrition with Honors, May 2015
Thesis: *Contribution of Organ Size to Adaptive Thermogenesis during Caloric Restriction*

New York University – New York, NY
College of Arts and Science
Bachelor of Arts, May 2014 **Major:** Psychology **Minor:** Chemistry/ Child and Adolescent Mental Health Studies

Professional Experience

American Medical Association- Medical Student Section, *UIWSOM Student Delegate* Jan. 2019- Present

- Serve as a liaison between the American Medical Association and the student body and serve as a link in representing the interests of the UIWSOM student body in advocacy and policy during the AMA House of Delegates at annual conferences.

Street Medicine San Antonio, Executive Board Member August 2018- Present

- Advocated for & provided direct provision of health care to the unsheltered homeless where they live through collaboration with credentialed faculty & community organizations.
    - Participated in the Point-In-Time Homeless Street/Shelter Count through the South Alamo Regional Alliance for the Homeless. The Count is an effort to learn more about the individuals & families experiencing homelessness in San Antonio to accomplish local/federal goals toward ending homelessness.
- Volunteer Training coordinator for the inaugural chapter.
- Street Rounds participant, providing immediate wound care/healthcare to individuals experiencing homelessness.

Student Osteopathic Medical Association (SOMA), *Executive Board Member* April 2018- Present

- Co-authored a grant provided by national SOMA to support an educational pilot and ***collaborative partnership*** between community organizations including the **San Antonio Food Bank**, **H-E-B**, & **Southside Independent School District (SISD)**.
    - The San Antonio Food Bank offered a free educational class on diet and healthy eating habits to a cohort of 40 families from the SISD community.
    - The research component of this initiative to assess through self-management support groups conducted prior to the food demo whether there was an increase in self-motivation & confidence by lowering barriers through service delivery (nutrition education, cooking class, recipes, transportation, groceries).
- Authored a grant provided by national SOMA to pilot mini DO-Day, an event designed to mirror DO Day, an annual advocacy day when osteopathic medical students travel to Capitol hill to advocate for our profession and legislation concerning health policies both past and present.
    - 25 medical students led a conglomerate of break-out sessions, revolving around advocacy, education, and health empowerment, attended by 75 high school students at SISD. The sessions included: CPR Demos, Introduction to Physical Exams, Pelvic Model Examinations, Heart Health, Art & Mental Health Facilitated Discussions, and an Introduction to OMT.
- Inaugural UWISOM chapter was awarded the **Excellence in Promoting Osteopathic Medicine Award** from the national SOMA board.

American Medical Women's Association, Women in Osteopathic Medicine Chapter Jan. 2018- Present

- Hosted national co-chairs of the Physicians Against the Trafficking of Humans (PATH) initiative to train UIWSOM students, in addition to over 60 audience members including healthcare professionals, community partners (forensic nurses, law enforcement, district attorney, and local shelters) through the L.I.F.T. (Learn, Identify, and Fight Human Trafficking) training

- Co-authored an American Medical Association resolution on the importance of providing medical students with training on how to identify human trafficking in their preclinical years to prepare them for clinical rotations.

Texas Medical Association, Medical Student Section Jan. 2018- Present

- Proposed & hosted a two-day inaugural "Safe DO" program on our campus, an education training program focused on sexual assault awareness and prevention with an osteopathic, interdisciplinary component to holistically address the dynamic interaction of mind, body, and spirit in patient care as it relates to providing care & support to sexual assault victims.
- Conducted a research study before/after the training to assess the perspectives and awareness of medical students on identifying, reporting, and providing resources to those who have experienced sexual assault.
- ***Texas Medical Association Medical Student Section Representativ***e on the **Committee on Reproductive, Women's, and Perinatal Health (July 2019-Present)**

Mentality Initiative to Nurture Doctors (M.I.N.D.), Executive Board Member October 2017- Present

- Served on the inaugural executive board as an advocate for mental health awareness and promotion through student-led initiatives such as biweekly reflections & inaugural Week of Wellness on campus.

New York University Langone Medical Center, Department of Medicine July 2016- July 2017

Research Data Associate, Mobile Insulin Titration Implementation (MITI) study

- Perform clinical patient & staff interviews to assess perceptions of, willingness to use, acceptability and barriers towards the MITI intervention.
- Organize data collected via electronic chart review to estimate cost savings from reduced utilization of services and differences in the cost of the diabetes medication regimen.

Publication:

1. Langford AT, Wang B, Orzeck-Byrnes NA, **Aidasani SR**, Hu L, Applegate M, Moloney DN, Sevick MA, Rogers ES, Levy NK. Sociodemographic and clinical correlates of key outcomes from a Mobile Insulin Titration Intervention (MITI) for medically underserved patients. *Patient Education and Counseling.* 2019;102(3):520
2. Levy NK, Orzeck-Byrnes NA, **Aidasani SR**, et al. Transition of a Text-Based Insulin Titration Program From a Randomized Controlled Trial Into Real-World Settings: Implementation Study. Eysenbach G, ed. *Journal of Medical Internet Research*. 2018;20(3):e93.
3. Rogers E, **Aidasani SR**, Friedes R, Hu L, Langford AT, Moloney DN, Orzeck-Byrnes N, Sevick MA, Levy N. Barriers and Facilitators to the Implementation of a Mobile Insulin Titration Intervention for Patients With Uncontrolled Diabetes: A Qualitative Analysis. *JMIR Mhealth Uhealth*. 2019;7(7):e13906.

Clinton Global Initiative University 2016 Dec. 2015- Present

Student Commitment Maker

- Proposed a cross-cultural female health hygiene mentorship program, which leverages cutting-edge technologies to facilitate the rehabilitation of women and girls who have undergone female genital cutting.
    - Pilot workshop series conducted in succession in 2 major cities—Freetown, Sierra Leone & New York, US.

New York Obesity Research Center, Columbia University Medical Center, *Research Assistant* Nov. 2014- Dec. 2015

- Advanced image analysis using MRI & CT scans to accurately measure body composition changes within various diseases using the sliceOmatic software.
- Conducted literature reviews to collaborate one-on-one with my thesis mentor, Dr. Wei Shen, in grant writing/editing.

Publication: First author on two abstracts:

1. "The Relationship between Visceral Adipose Tissue/Bone Marrow Adipose Tissue and Cortical Bone Area in Children and Adults" presented at Tufts 9th Future of Food & Nutrition Conference in April 2016.
2. "Visceral fat and muscle changes during 6-week chemotherapy in pediatric Hodgkin lymphoma" presented at June 2016 American Society of Clinical Oncology Annual Meeting.

United Nations Children's Fund (UNICEF), Nutrition in Emergency Unit, *Research Intern* Aug. 2015- Dec. 2015

- Strengthened guidance on integration and scale-up of Severe Acute Malnutrition (SAM) management into East and Southern African health systems.
- Conducted extensive literature review to provide a comprehensive and accurate analysis of existing approaches to support integration/scale-up of management of SAM globally.

- Facilitated the development and provision of technical guidance and tools to governments and implementing partners.
- Collaborated with UNICEF country/regional officers to develop key recommendations to form the basis of the taskforce roadmap:
    - Aiming to maximize the synergies between members and partners and areas of strategic cooperation for supporting the implementation of key recommendations.

New York Methodist Hospital, Department of Cardiology June 2013- Sept. 2013
Summer Research Internship Program
- Observed Dr. John Heitner, Director of Non-Invasive Cardiology, during cardiac MRI readings.
- Learned tracing of the left & right ventricle on MRI images to estimate cardiac metrics like the ejection fraction.

New York Allergy and Sinus Center, *Medical Assistant/Receptionist* June 2012- March 2013
Columbia University/New York State Psychiatric Institute May 2012- Sept. 2012
Child Psychiatric Epidemiology Group*, Stress and Justice Study Research Intern*
- Studied the impact of parental exposure to the criminal justice system and transmission of stress to their children.
- Conducted child/adult interviews in the field & contributed to data collection using Dialogix, CDISC, CIDI software.

North Shore University Hospital, Department of Emergency Medicine June 2012- Sept. 2012
Volunteer Research Internship Program
- Interacted with patients in a busy emergency department to collect data for a palliative care study.
- Conducted literary reviews, patient screening tasks, data management duties and basic scholarly writing.

The Yinova Center, *Receptionist* June 2011- March 2012
The LifeHouse Chiropractic, *Intern* July 2011- Sept. 2011
America Reads/America Counts, *Tutor* Sept. 2010- June 2011

Leadership Experience

Immigrants' Narratives & Health Seminar Sept. 2016-Present
Master Scholars Program in Humanistic Medicine, NYU School of Medicine
- Focuses on the stories of immigrants in the US, and how their journeys, experiences, and culture mediate their diverse experiences with health and illness. Goals of class include enhancing narrative and structural competency.

Global Fund for Women's NYC Vanguard Advisory Council Aug. 2016- Present
- Founding group of young professionals dedicated to supporting Global Fund for Women by raising awareness of the organization's mission, fundraising to support the organization, and empowering women.

Delta Kappa Delta Sorority, Inc., *National Service Director* June 2015- Present
Delta Kappa Delta Sorority, Inc., *Northern Regional Director* June 2014- June 2015
Columbia University Medical Center/The Josiah Macy Jr. Foundation Macy Scholar Jan. 2015- May 2015
- Inter-professional education seminar examining current issues in healthcare through an interdisciplinary lens.
- Received narrative medicine training & gained practical experience through small-group work in clinical care settings focusing on teamwork and collaboration.

Institute of Human Nutrition, *Student Representative Committee* Aug. 2014- May 2015
- Student Representative for university-wide Sexual Violence Response committee, Community Service, & Speak Up!

New York University Alternative Breaks Program, *Site Leader* Sept. 2011- May 2014
- Co-led a group of 10 participants on three domestic trips around the country in a service-immersion program relating to medical care for special needs children, at-risk youth & prison justice, and domestic violence, each year, respectively.

NYU SERVE!, *Facilitator* Sept. 2013- May 2014
- Co-led service organization for commuter students, focusing on social justice issues & safe space for constructive dialogue.

Delta Kappa Delta Sorority, Inc. at New York University, April 2012- May 2014
Vice President, Fundraising Chair, Service Chair, Multi-cultural Greek Council VP of Philanthropy
NYU Pre-Health Advisory Board, *Executive Board Member* Sept. 2010- May 2014
NYU Undergraduate Cultural Training Program, *Participant* Sept. 2011- June 2012

Awards, Honors, Skills

- 2014 NYU President's Service Award (recognize students who have made significant contributions to the university community in the areas of learning, leadership, and quality of student life).
- Delta Kappa Delta Sorority, Inc National Awards: The 2013/2014 Silver Lining Award (Highest Service Hours Completed Nationally) and The Everlasting Flame Award (Given to a sister who displays indomitable spirit).
- Language: Fluent in English, Hindi, and Sindhi; basic-level 1 Spanish.
- Technical Skills: Proficient in Microsoft Office, R, SPSS, Slice-O-Matic (MRI image analysis software).

Sneha Aidasani

Diversity Statement
Application for AMA-MSS Regional Delegate and Alternate 2020

Throughout my time at the University of the Incarnate Word School of Osteopathic Medicine, I have seen a commitment by faculty to individualize the patient-physician relationship, recognizing that each patient brings their own biological, psychological, and sociological needs-- the "dynamic interaction of the body, mind, and spirit." This emphasizes the importance of the patient's narrative, and its role in the quality of care a patient receives. In this way, osteopathic medicine, in my eyes, allows us, as student doctors and future health-care professionals, to meet patients at their most vulnerable, yet allow ourselves to adapt vulnerability as well.

To recognize the value of a patient's narrative, a healthcare professional must be empathetic. If a healthcare professional brings empathy, the patient will bring trust. My personal goal in training to become more cognizant of the patient narrative is to not only enhance my own narrative competency, but also my structural competency, using the narrative as a jumping point to bridge existing gaps within institutions and laws that structure the patient narrative.

As a student of the first entering class at the University of the Incarnate Word School of Osteopathic Medicine, and as a founding executive board member for our school's Student Osteopathic Medical Association, I have been given the opportunity to pilot community-based initiatives with three core goals: education, advocacy, and empowerment. Two such initiatives included "¡SOMA Cenas! Nutrition Kitchen" (an educational pilot and *collaborative partnership* between community organizations including the San Antonio Food Bank, H-E-B, & Southside Independent School District) and "Mini DO-Day" (a conglomerate of multiple workshops/sessions offered to high school students at Southside Independent School District, revolving around advocacy, education, and health empowerment). Through collaborative community partnerships, we strived to empower community members with health education and career-awareness to motivate them to break through the socioeconomic barriers and chronic health challenges that they face.

I hope to continue to work towards the University of the Incarnate Word School of Osteopathic Medicine's mission of "…*community responsive care for all patients*…" –providing social justice oriented, compassionate health care to the underserved population of Southeast San Antonio by truly listening to their individual narratives. I see medicine as an opportunity to not only be a physician, but an educator. My clinical research and leadership experiences during my post-graduate experience at Columbia University's Institute of Human Nutrition and currently, at the University of the Incarnate Word School of Osteopathic Medicine, have taught me the impact health education can have on patients from vulnerable populations, especially if health literacy and other challenges are pro-actively accounted for. With my professional background in public health and nutrition, I hope to utilize my platform as a student doctor and future physician to not only treat, but also to bring education to neighboring communities that lack scientific dialogue, in order to encourage healthy lifestyle modifications.

I would like to thank the American Medical Association Medical Student Section for providing this opportunity to serve as Regional Delegate/Alt. Delegate to students like myself whose vision remains to address health inequity and gaps in the accessibility and affordability of community-based healthcare. As a first-generation immigrant woman pursuing a doctorate, I hope this position will give me the opportunity to learn about and provide a voice to issues my colleagues feel are of relevance to our professional journeys today. In addition, I hope these interactions with my learned peers will further support my educational endeavors in narrative medicine, and also motivate me to continue my reflective journey on this path to becoming an advocate for my patients as a future osteopathic physician.

Application for AMA-MSS Regional Delegate and Alternate- 2020

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Josh (First) Landry (Middle) Bilello (Last)

Address: 921 Marine Dr. Apartment #310 (Street address)

City, State, Zip: Galveston (City) TX (State) 77550 (Zip)

Telephone: 972-922-9623 (Day) 972-922-9623 (Evening)

Email address: jobilell@utmb.edu

Medical School: University of Texas Medical Branch

Expected graduation: May 2022

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Region

Signature of State Delegation Chair or State Medical Society EVP: David Henkes MD

Signatory's name and title (Please print): David N. Henkes, MD, Chair, TX Delegation State: TX

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Ruth Levine MD

Signatory's name and title (Please print): Ruth E. Levine, MD Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Joshua Bilello

jobilell@utmb.edu – (972) 922-9623
921 Marine Dr. Apartment 310 Galveston, Texas 77550

Education

Oklahoma Christian University
Bachelor of Science (B.S.), Computer Engineering
2013-2017

University of Texas Medical Branch
Doctorate of Medicine (M.D.)
2018-Present
Anticipated Graduation Year: 2022

WORK EXPERIENCE

Starbucks Barista
June 2012 – August 2013
Starbucks
Dallas, TX and Edmond, OK
Responsibilities:

- Demonstrated excellence in customer service
- Received three M.U.G. Awards, which recognize employee innovation
- Cleaned and maintained supplies, tools, equipment, and storage areas in order to ensure compliance with safety regulations

Engineering Summer Academy Mentor
August 2015 and August 2016
Oklahoma Christian University
Edmond, OK
Responsibilities:

- Mentor for six incoming freshman engineering students for one week
- Responsible for providing technical aid, encouraging teamwork among students, and giving career guidance
- Assisted in guiding students with projects from various fields of engineering

Teaching Assistant
January 2015 – April 2015
Oklahoma Christian University
Edmond, OK
Responsibilities:

- Assisted Professor Smith with weekly projects
- Aided students in completing technical milestones, troubleshooting hardware and software, and providing supplemental instruction
- Graded student notebooks for thorough documentation

Software Engineering Intern
May 2016 – April 2017
The Boeing Company
Oklahoma City, OK
Responsibilities:

- Worked alongside a team of thirty software engineers
- Utilized Visual Basic Application and Visual Basic Script to update existing scripts and databases
- Attended various learning sessions for interns

Software Engineer
June 2017—July 2018
Lockheed Martin Corporation
Grand Prairie, TX
Responsibilities:

- Create and refactor C# and C++ code for ground missile launchers
- Attend weekly meetings and status updates
- Test and verify software is working on launchers

Volunteering

Clinic Volunteer
August 2014 – July 2016
Manos Juntas
Oklahoma City, OK
Hours: 70
Responsibilities:
- Documented vitals and symptoms; recorded patients' medical histories
- Interacted with physicians and other healthcare professionals
- Experienced community medicine in a disadvantaged area

Mercy Hospital Volunteer
August 2014 – April 2015
Mercy Hospital
Oklahoma City, OK
Hours: 63
Responsibilities:
- Assisted doctors, nurses, and physician assistants
- Provided post-operative care and physical assistance to patients

Delete Blood Cancer Volunteer
April 2016
Delete Blood Cancer
Edmond, OK
Hours: 55
Responsibilities:
- Swabbed donors for saliva samples
- Recorded data of donors to ensure accurate information
- Registered 300 new donors to bone marrow donor database

American Red Cross Volunteer
December 2015 and April 2016
American Red Cross Measles & Rubella Initiative
Edmond, OK
Hours: 60
Responsibilities:
- Assisted in money handling and providing instructions for students on how to take notes
- Raised money for initiative by providing notes for students to give to other students during finals week

Men of Nehemiah Volunteer – May 2014
August 2014 and May 2015 – August 2015
Men of Nehemiah
Dallas, TX
Hours: 120
Responsibilities:
- Bought groceries before meals were cooked
- Prepared meals for over 300 disadvantaged people
- Led small Bible study with men after breakfast

Food Bank Volunteer
May 2014 – June 2014
Dallas Food Bank
Dallas, TX
Hours: 40
Responsibilities:
- Packed boxes and helped organize in a timely manner

Vacation Bible School Volunteer
June 2015
Coppell Bible Fellowship
Coppell, TX
Hours: 40
Responsibilities:
- Cared for group of nine year olds for several hours each day
- Guided them through various activities throughout the week

Baseball Tournament Volunteer
June 2015
AAYBA Baseball
Lewisville, TX
Hours: 45
Responsibilities:
- Tended to baseball fields, directed people to their intended locations, and helped set up electronics
- Organized home run derby and infield competition for all competing teams

Minor League Baseball Volunteer
May 2014 – June 2014
Frisco Roughriders
Frisco, TX
Hours: 50
Responsibilities:
- Helped with concessions, directed parking, and ushered fans to their assigned seating

Medical Student Volunteer
August 2018 – Present
St. Vincent's Student Clinic
Galveston, TX
Hours: 60
Responsibilities:
- Provide healthcare to underfunded patients
- Participate in workshops dedicated to teaching patients about their physical and mental health

Honors and Awards

Freshman Computer Engineer of the Year
April 2014
This award is given to one computer engineering student per academic classification. It is based on grade point average, work ethic, and leadership among students in the computer engineering department.

Chaffin Family Engineering Scholarship
April 2014
This endowed scholarship is given to one electrical and computer engineering student during their sophomore year. This award recognizes students who promote excellence among their engineering peers.

Sophomore Computer Engineer of the Year
April 2015
This award is given to one computer engineering student per academic classification. It is based on grade point average, work ethic, and leadership among students in the computer engineering department.

President's List
December 2013, April 2014, April 2015, December 2015, April 2016, December 2016, April 2017
This award is given to students who earn a semester grade point average of 4.0.

Honor Roll
December 2014, April 2016
This award is given to students who earn a semester grade point average of 3.5 or above.

Love's Entrepreneur's Cup Winner
April 2017
The Love's Entrepreneur's Cup is a business competition for college students in Oklahoma. Teams are vigorously judged on their presentation skills, business plan, and answers to questions from judges. The team, VisuALS, took the top prize in this competition.

Senior Computer Engineer of the Year
April 2017
This award is given to one computer engineering student per academic classification. It is based on grade point average, work ethic, and leadership among students in the computer engineering department.

Summa Cum Laude
April 2017

This academic distinction is awarded to students with a 3.85 GPA or above upon completion of their degree.

Anderson Scholar
August 2018
This award is given to medical students pursuing a Doctor of Medicine degree.

Henry Renfert Scholar
August 2019
This award is given to students in the medical degree program of the School of Medicine.

Stjepcevich Scholar
August 2019
This award is given to students directed by a faculty selection committee.

Leadership, Teamwork & Clubs

VisuALS Engineering Capstone Team Lead
January 2016 – April 2017
Oklahoma Christian University
Responsibilities:
- Conducted weekly meetings with teammates and mentors
- Communicated with faculty mentor about progress of project
- Ensured a timely completion of multiple project milestones
- Led discussion with patients at an ALS support group at Integris Hospital to ensure the product was applicable to their needs
- Approved all time logs and documentation produced by team

Vice-President of Kappa Mu Epsilon
January 2015 – April 2017
Oklahoma Christian University
Responsibilities:
- Presided in absence of the president
- Organized meetings
- Communicated with Math faculty members and sponsors
- Connected students and provided tutoring options for students that needed help in their respective mathematics courses

Eagles Health Initiative Founding Council Member and Treasurer
June 2015 – April 2017
Oklahoma Christian University
Responsibilities:
- Coordinated at least one health related event each semester
- Voted on significant club decisions
- Contributed to all official documentation
- Promoted physical, mental, and spiritual health among students and surrounding communities
- Tracked all account deposits and withdrawals
- Kept detailed financial records using extensive spreadsheets that showed annual expenses and gross income from membership dues

Toastmasters International
June 2016 – April 2017
Oklahoma Christian University
Responsibilities:
- Prepared 5-10 minute speeches on a chosen topic
- Evaluated peers and gave constructive criticism
- Kept track of speech time and noted inappropriate grammar

VisuALS Co-Founder & CPO
August 2016 – April 2017
Oklahoma Christian University
Responsibilities:
- Led team in business meetings with technical advisors
- Formulate and kept team to strict schedule
- Point of contact with media and news outlets
- Researched product competitors and market for this product
- Wrote extensive financials on product price vs. competitors

VisuALS Technical Advisor
August 2016 – April 2017

Oklahoma Christian University
Responsibilities:

- Consulted on technical matters with other executives and team members
- Keep in daily communication with business executives and programmers

American Medical Association Student Delegate
January 2019 – Present
University of Texas Medical Branch
Responsibilities:

- Work with other medical student delegates from across the country to write and pass AMA resolutions
- Give testimony for or against various resolutions
- Authored three separate resolutions to be presented at A19 and I19

Committee on Health Information Technology (CHIT) Member
July 2019 – Present
American Medical Association
Responsibilities:

- Research and produce reports and resolutions on gaps in current MSS and external policy
- Draft novel policy regarding topics such as electronic medical records, medical data standards, telemedicine, and other health information technology topics

Gastroenterology and Gastrointestinal Surgery Student Society Officer
May 2019 – Present
University of Texas Medical Branch
Responsibilities:

- Provide shadowing opportunities in gastroenterology and gastrointestinal surgery for students that are interested in GI related specialties
- Host workshops allowing students to acquire useful clinical skills
- Host Q/A sessions with faculty, residents, and senior medical students

Region III Resolution Committee Member
September 2019 – Present
American Medical Association
Responsibilities:

- Review resolutions submitted for the MSS Interim 2019 conference
- Summarize key points of each submitted resolution to share with Region III
- Write testimony for resolutions to submit to the Virtual Reference Committee

Reserves of the Medical Student Council
September 2019 – Present
Society of Interventional Radiology
Responsibilities:

- Participate in projects relating to the field of Interventional Radiology
- Participate in council meetings once a month

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

It is important for a qualified region III delegate to possess traits that advocate for equality of rights amongst all populations, especially minority populations. In order to successfully advocate for these rights, a delegate must be able to emphatically understand the implicit and explicit barriers that minority populations face when accessing healthcare. I believe at the core of diversity is the importance of working with and providing equal care to underrepresented groups.

As a medical student, I have worked extensively on research regarding the LGBTQ+ minority group and had hands-on experience helping the indigent population in a volunteer clinic. For research, I have been focusing on the disparity between LGBTQ+ medical education curriculum and medical curriculum devoted to other population groups. This research is being conducted in an effort to campaign for the inclusion of LGBTQ+ medical education curriculum as the standard for medical schools across the nation. In addition to fighting for the standardization of LBGTQ+ medical education, I have also been involved in research which illuminates the dangers of conversion therapy for LGBTQ+ children and young adults, advocating for the ban of this therapy. I believe that this research is foundational in creating curriculum and policy for the LGBTQ+ group, which has been historically underrepresented in the medical field. In addition to research and policy, I have also been a volunteer at Galveston's local free health clinic that serves the uninsured population. Volunteering has truly given me perspective to understand the barriers that the indigent population faces when attempting to access quality medical care. Through these experiences, I have been exposed to populations of different backgrounds and learned how to use my professional skills to better serve these populations to create more equal healthcare within the field of medicine.

As a region III delegate, I will make it a priority to understand the barriers that minority and underrepresented groups face when attempting to access healthcare by diligently listening to their experiences. As a person in leadership, I believe it is my responsibility to listen to people's stories, fully understand the scope of their plight and take these experiences into consideration in order to create impactful change. As an elected delegate, I will also fight to ensure the American Medical Association Medical Student Section presents an egalitarian platform for all populations, ensuring that all minorities have equal representation. Now more than ever, racial and ethnic minorities are facing barriers regarding access to medical care. It is vitally important to ensure every minority has a voice at the leadership level, especially when it comes to healthcare policy.

I believe respecting one another, fighting for one another, and listening to one another are critical pieces to help medical professionals accomplish more in the fight for equal healthcare for all populations. Diversity enriches conversations on this topic by creating new perspectives and opportunities to provide solutions for all people. I believe this is what it means to be a champion of fairness and equality in the medical field as a student and future professional.

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: James (First) Marion (Middle) Bunch (Last)

Address: 5001 Chicago Ave Apt 913 (Street address)

City, State, Zip: Lubbock (City) TX (State) 79414 (Zip)

Telephone: (505) 227-0333 (Day) some (Evening)

Email address: james.buncb@ttuhsc.edu

Medical School: Texas Tech University HSC - Lubbock

Expected graduation: May 2022

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: David Henkes MD

Signatory's name and title (Please print): David N. Henkes, MD, Chair, TX Delegation to the AMA State: TX

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Lauren Cobbs MD

Signatory's name and title (Please print): Lauren Cobbs MD

NOTE TO ADDICTEES: YOUR ADDICTION WILL NOT BE CONSIDERED COMPLETE, AND YOU WILL NOT BE PERMITTED TO [illegible] until you have submitted the required signs.

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Email: mas@ama-assn.org

JAMES M. BUNCH II

5001 Chicago Ave. Apt. 913, Lubbock, Texas, 79416| (505)227-0333 | james.bunch@ttuhsc.edu

EDUCATION

Texas Tech University Health Sciences Center
Doctor of Medicine **2022**
Anticipated graduation May 2022

Master of Science **2018**
Medical Education/Graduate Medical Sciences
May 2018

Texas Tech University
Master of Business Administration **2019**
Health Organization Management, Rawls College of Business
August 2019

Bachelor of Arts **2016**
Chemistry
Minors in English and Biology
Honors: Cum Laude and "With Honors," May 2016

AWARDS

Rawls College of Business Administration Scholarship, *Texas Tech University* **2018, 2019**
School of Medicine Scholarship, *Texas Tech University Health Sciences Center* **2018, 2019**
Deans' Choice Award, *Texas Tech University Health Sciences Center* **2018**
GSBS Scholarship, *Texas Tech University Health Sciences Center* **2017-2018**
Presidential Scholar, *Texas Tech University* **August 2012 – May 2016**
Dean's List, *Texas Tech University* **Fall 2012, Fall 2013, Fall 2014, Spring 2015, Fall 2015, Spring 2016**

RELATED AND HEALTHCARE EXPERIENCE

Texas Tech University Health Sciences Center, Lubbock, TX
President, Class of 2022 **2018-Present**

- Elected as President of the School of Medicine class of 2022 to represent official positions of the class and negotiate curriculum with School of Medicine Administration.
- Developed and executed vision statements for all official class officers, activities, and agendas.
- Supervised the formulation of budgets and collection and use of class funds.

President's Select **2019-Present**

- Ambassador on behalf of the Office of the President and Texas Tech University Health Sciences Center
- Network with donors and prospective students to promote the University's interests.

Texas Tech Apprenticeship Program, Covenant Medical Center Emergency Department **2019-Present**

- Currently completing a preceptorship in the Emergency Department at Covenant Medical Center in Lubbock,
  TX. with Dr. Juan Fitz focusing on patient-oriented skill development.

Secretary & Treasurer, Region III Executive Leadership, American Medical Association **2019-Present**

- Elected to the executive board of the American Medical Association Region III Medical Student Section.
- Coordinating renewal of the Region III membership directory and participate in executive decision making for the region.

Board of Directors, TEXPAC **2019-Present**

- Selected to be a member of the executive leadership of the TMA's political action committee.
- Voted on confirmation of endorsements for candidates running of public office across the State of Texas.

Regional iCorps, National Science Foundation/ Co-founder Damadian Health **2019-Present**

- Co-founded a medical start-up centered on innovation and research around Deep Vein Thromboses.
- Participated in customer discovery through the National Science Foundation iCorps Program.

Board of Directors, Our Legacy Now Student Foundation **2019-Present**

- Selected to be a member of the executive leadership of the Our Legacy Now Student Foundation.
- Voted on awards of emergency financial aid to students at TTUHSC.

Delegate (Alternate), Texas Medical Association **2018-Present**

- Selected as one of two delegates with voting authority to the legislative body of the Texas Medical Association.
- Co-authored policy adopted by the TMA geared at protecting fiscal viability of rural health systems.

Delegate (Alternate), American Medical Association **2018-Present**

- Selected as one of two delegates with voting authority to the legislative body of the American Medical Association Medical Student Section.

Member, Curriculum Review Committee **2019-Present**

- Selected to be a member of a curriculum review committee for the Major Organ Systems Block.
- Helped review assessment procedure and exam questions for the following medical school class.

Chairman, Medical Student Government Committee on Constitution and Bylaws **2019-Present**

- Chaired the MSG Standing committee responsible for review and recommendations on proposed bylaws and constitutional amendments.

Member, Dean's Contingency Fund Committee **2019-Present**

- Selected to be a member of the standing committee responsible for awarding travel funds for students.

Member, Medical Student Government Committee on Diversity **2019-Present**

- Selected to be a member of the standing committee responsible for promoting diversity and inclusion within the TTUHSC School of Medicine.

Member, Emergency Medicine Interest Group **2016-Present**

- Participated in various interest group events, including attending and teaching the annual wilderness medicine training.

Medical Student Free Clinic Volunteer **2016-Present**

- Coordinate treatment and health maintenance of local patients at the TTUHSC *Pro Bono* Family Medicine Clinic

Teaching Assistant, Texas Tech University Health Sciences Center School of Medicine **2017-2018**

- Aided School of Medicine Faculty teaching first year medical students and managed other Teaching Assistants in the cohort.
- Authored original research by developing novel clinical experiences for first and second year medical students

Shadowing, Dr. Catherine Ronaghan, M.D. **2018**

- Observed Dr. Ronghan in the UMC Operating Room. Learned relevant physical exam techniques and diagnostic criteria for various traumatic surgical conditions.

Shadowing, Dr. James Tarbox, M.D. **2017-2018**

- Observed Dr. Tarbox in the Texas Tech Physicians internal medicine/allergy clinic. Learned relevant physical exam techniques and diagnostic criteria for various allergic and immunological conditions.

Covenant Medical Center, Lubbock, TX
Quality Assurance Specialist, Scribe America **2015-2016**

- Audited Staff for documentation quality, as well as facilitated continuing employee education within the Emergency Department.

Staff Scribe, Scribe America **2015-2016**

- Worked closely with both allopathic and osteopathic physicians in order to accurately document patient encounters, procedures, and dispositions within the Emergency Department. Represents approximately 2000 clinical hours.

Emergency Department Intern Coordinator **2014-2015**

- Developed program resources, trained, and facilitated an intern program in the Emergency Department for undergraduate pre-medical and pre-nursing students.

Shadowing, Dr. James Williams, D.O. **2014-2016**

- Shadowed and discussed patient cases with Dr. Williams throughout multiple Emergency Department Shifts.

Emergency Department Intern **2013-2014**

- Worked closely with Emergency Department staff to increase efficiency, improve work-flow, and bolster patient experience.

RESEARCH EXPERIENCE

Texas Tech University Health Sciences Center

Department of Medical Education **May 2017 – Present**

- Developed a new Graduate Medical elective aimed at the improvement of early clinical training for first-year medical students.
- Authored original research investigating the efficacy of experiential learning in a medical education setting.

Texas Tech University

University Medical Center & Rawls College of Business Administration **May 2019 – Present**

- Studied throughput in the outpatient Emergency Center with the goal of reducing variance, waste, and patient wait-times.

PROFESSIONAL PRESENTATIONS AND WORKSHOPS

Bunch J, Piel C, Howell T. Analysis of Room to Physician Time in the Emergency Department Aimed at Increasing Throughput in an Emergency Setting. Poster Presentation, Jerry S. Rawls College of Business Administration Beusseler Lecture Series. Lubbock, Texas.

Bettiol P, Bunch J. Studying the Fiscal Viability of Rural Hospitals. Texas Medical Association Policy. Adopted Spring 2019. Dallas, Texas.

Bunch J, Webster D, Brower GL. Efficacy of Clinical Skills Education For First-Year Medical Students Using Simulated Emergency Department Patient Encounters. Proceedings of the Texas College of Emergency Physicians Annual Conference in Austin, Texas.

Bunch J, Webster D, Brower GL. Benefits of Early Clinical Exposure Using Simulated Patient Encounters for First-Year Medical Students. Poster presentation at the 2019 Experimental Biology Conference in Orlando, Florida.

Bunch J, Webster D, Brower GL. Examining Early Clinical Exposure Using Simulated Patient Encounters for First-Year Medical Students. Poster presentation at the 2018 American Physiological Society Institute on Teaching and Learning in Madison, Wisconsin.

PROFESSIONAL CONFERENCES ATTENDED

World Conference on Ultrasound in Medical Education, September 2016. Lubbock, TX.
Wilderness Medicine Training Workshop, March 2016. Junction, TX.
Texas Tech University Health Sciences Center Student Research Week, March 2017. Lubbock, TX
Wilderness Medicine Training Workshop, March 2016. Canyon, TX.
Institute on Teaching and Learning, American Physiological Society, June 2018. Madison, WI.
Texas Medical Association Winter Meeting, January 2019. Austin, TX.
Medical Student Advocacy and Regional Conference, March 1019. Washington, DC.
Texas College of Emergency Physicians Annual Meeting, March 2019. Austin, TX.
Experimental Biology, American Physiological Society, April 2019. Orlando, FL.
TexMed, Texas Medical Association, April 2019. Dallas, TX.
Annual Meeting of the American Medical Association, June 2019. Chicago IL.

HOBBIES AND PERSONAL INTERESTS

Painting (Acrylic Landscapes and Abstraction)
Cooking (Traditional New Mexican, French, and English Cuisine)
Theatrical Arts (Musical Theatre, Ballet, Traditional Theatre)
Personal Computer Design and Improvement

LANGUAGES

English – Native Speaker.

PROFESSIONAL AND EXTRACURRICULAR MEMBERSHIPS

Texas Medical Association
American Medical Association
International Association of Medical Educators
Texas College of Emergency Physicians
American College of Emergency Physicians
ACEP Emergency Medicine Residents' Association
TTUHSC SOM Emergency Medicine Club
American Chemical Society
American Physiological Society
Knights of Columbus, Third Degree

Diversity Statement

Diversity in medical education and the practice of medicine is something that is important to me. To me the idea of diversity is one that values diverse backgrounds and experiences. I think that I will be able to contribute to the diversity of the House of Delegates in several ways. One reason I will be able to contribute to a diverse representation is my experience in terms of the location of my school and the patient population we serve. During my training in Lubbock, which has a very large catch area, I have had the opportunity to network and connect with a diverse group of patients from both rural and urban settings. Furthermore, Texas Tech is located on the border of Texas and New Mexico, allowing the opportunity to take care of patients that have to travel, sometimes hundreds of miles, to receive healthcare. The combination of rural and urban populations, which is especially evident in our Free Clinic, allows for a unique perspective on some of the hardships that patients must overcome to receive quality healthcare in West Texas.

Another way that I will be able to contribute to the diversity of the HOD is through my work on our Medical Student Government special committee on diversity. In early April of 2019 the Wall Street Journal reported that the Texas Tech School of Medicine had come to an agreement with the Office of Civil Rights to eliminate race from our admissions criteria. The story was quickly picked up by numerous news outlets, including the New York Times and NPR. The deal also prompted a statement from the current president of the AMA, Dr. McAneny, condemning the move. As president of the medical student body, I was one of the students at Texas Tech that was included in the initial talks about how the school would respond to the negative press and would reaffirm that diversity is valued at Texas Tech. As a founding member of our Medical Student Government committee on diversity I have helped craft the long term response and strategic plan for Texas Tech going forward and have helped to affirm to the nation and to prospective applicants that diversity is important and is valuable. I think that my experience gained in responding to this move will help me to contribute to the diversity of the AMA and the House of Delegates.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Abhishek (First) Jay (Middle) Dharan (Last)

Address: 150 Raynolds St Apt 16 (Street address)

City, State, Zip: El Paso (City) TX (State) 79905 (Zip)

Telephone: (480) -406-0405 (Day) (Evening)

Email address: abhishek.j.dharan@ttuhsc.edu

Medical School: Foster School of Medicine at Texas Tech El Paso

Expected graduation: 2022

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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Signature of State Delegation Chair or State Medical Society EVP: David Henkes MD

Signatory's name and title (Please print): David N. Henkes, MD, Chair, TX Delegation State: TX

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Charmaine Martin

Signatory's name and title (Please print): Charmaine Martin

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Email: mss@ama-assn.org

Abhishek Dharan

(480)-406-0405 | abhishek.j.dharan@gmail.com | US Citizen

EDUCATION

Texas Tech University Health Sciences Center El Paso **July 2017 - Present**
Foster School of Medicine
- *Scholar in Primary Care*

B.S.E. in Electrical Engineering, *summa cum laude* **Aug 2010 - May 2014**
Barrett, The Honors College at Arizona State University
Thesis/Capstone: *"Developing a Broadband Amplifier for Analysis of DNA Structural and Molecular Characteristics"*
Director: *Michael Goryll, PhD*
- *Senior Design Award (2014)* — Top EE senior design capstone project at ASU

WORK EXPERIENCE

CEMOSoft LLC — El Paso, TX **Jan 2018 - Present**
Healthcare Consultant
- Help define opportunities for existing technology deployment in healthcare sector

Minus Tau — El Paso, TX **Aug 2017 - Jun 2018**
Systems Engineering Consultant
- Helped local biotechnology startup with system component design and creating internship program

CEMOSoft LLC — Dallas, TX & Austin, TX **Oct 2015 - May 2017**
Marketing and Technology Development Engineer
- Helped grow company from stealth mode to winning gov projects and partnering with top tech companies
- Managed projects with global development teams for US based customers

Texas Instruments — Sunnyvale, CA & Dallas, TX **Feb 2015 - Sep 2015**
Technical Sales Engineer
- Assigned to Palo Alto based automotive customer to track supply chain and lead internal design proposals
- Automated the pricing of $25M+/year of revenue across multiple accounts
- Identified new opportunities for new and existing accounts across Bay Area, California, and Southwest USA
- Experience with Bay Area sales office, pricing team, and customer service team

Physics Department at ASU — Tempe, AZ **Jan 2013 - May 2013**
Teaching Assistant
- Honors Physics with Calculus, Electricity and Magnetism course TA
- Graded homework and lab reports. Led lab sessions

Physical Education Department at Mesa Community College — Mesa, AZ **Jan 2013 - May 2013**
Adjunct Faculty - Taekwondo course substitute instructor

IEEE-USA — Washington DC **Jun 2012 - Aug 2012**
Policy Analyst
- Investigated the intersection of policy, technology, and engineering
- Completed focused research on Telemedicine and Broadband Expansion in the US
- Presented findings to the public at the Rayburn House of Representatives Office Building

PUBLICATIONS

Journal of Musculoskeletal Research, Apr 2016, *"The Effect of Freezing on Biomechanical Properties of the Carpal Tunnel Subsynovial Connective Tissue"*

Journal of Engineering & Public Policy, Sep 2012, *"Telemedicine: A Broadband Application Improving Healthcare Access and Efficiency"*

CONFERENCE POSTER PRESENTATIONS

Society for Student Run Clinics Annual Meeting, Mar 2019, Poster: *"Interventions to Increase Finance Outcomes at a Student Run Clinic"*, Autors: Kelsey Van Noy, Jocelyn Carnicle, Lynn Vu, **Abhishek Jay Dharan**, Nigel Abraham, Luke Kotin, Eliezer Hernandez, Laura Torres, Darya Falamarzi, Jaime Carrillo, Tracy Leonard, Charmaine Martin MD

Society for Student Run Clinics Annual Meeting, Mar 2019, Poster: *"Adapting Student-Run Free Clinics to Meet Patient Needs: A Contrast in Clinic Location and Outreach"*, Autors: Nigel Abraham, Luke Kotin, Eliezer Hernandez, Kelsey Van Noy, Jocelyn Carnicle, Lynn Vu, **Abhishek Jay Dharan**, Laura Torres, Darya Falamarzi, Jaime Carrillo, Tracy Leonard, Charmaine Martin MD

The 58th Annual Meeting of the Biophysical Society, Feb 2014, Poster: *"Chemical Cell to Cell Communication on Biomineralized Nanopore Substrates for Single Cell Analysis"*

AAAS Annual Meeting, Feb 2014, Poster: *"Chemical Cell to Cell Communication on Biomineralized Nanopore Substrates for Single Cell Analysis"*

AZ Bio Expo, Oct 2011, Poster: *"Fabrication of Microwell Arrays for Single-Cell Parameter Monitoring"*

INTERNAL CONFERENCE POSTER PRESENTATIONS IN MEDICAL SCHOOL

Annual Service Learning Symposium at TTUHSC-EP, Feb 2019, Poster: *"Sunland Park Children's Reading and Speech-Language Screening MLK Day Event"*, Authors: Subodh Potla, **Abhishek Dharan**, Axton Supnet

Annual Service Learning Symposium at TTUHSC-EP, Feb 2019, Poster: *"Hard Hats for Little Heads"*, Authors: Meenakshi Manivannan, Kristopher Van Huss, Amar Patel, & **Abhishek Jay Dharan**

RESEARCH EXPERIENCE

TTUHSC-EP Department of Ophthalmology — El Paso, TX **Oct 2018 - Present**
Medical Student Researcher

Engineering Research Center at ASU — Tempe, AZ **Aug 2013 - May 2014**
Research Assistant & Fulton Undergraduate Research Initiative (FURI) Grant Recipient

- Experimented growing cells on new materials under varying conditions to develop a drug testing platform
- Designed broadband amplifier from start to finish for Senior Design Capstone Project & ASU Honors Thesis

Mayo Clinic Department of Orthopedic Surgery — Rochester, MN **Jun 2013 - Aug 2013**
Research Fellow

- Designed experiment to test the effects of freezing on the mechanical properties of tissue in the Carpal Tunnel
- Validated past studies related to Carpal Tunnel Syndrome by showing negligent effects of freezing tissue
- Collaborated and coordinated with physicians and researchers from China and the Netherlands

Biodesign Institute at ASU — Tempe, AZ **May 2010 - May 2012**
Research Assistant & NASA Space Grant Recipient

- Only undergradaute to work independently in *class 100 cleanroom*
- Led microfabrication team on various projects and optimized MEMS devices used for cancer research
- Trained visiting researchers from Thailand and new graduate students

RESEARCH GRANTS

2018 - TEDx El Paso Technology Innovation Grant ($10,000)
2013 - Fulton Undergraduate Research Initiative Barrett Honors Thesis Research Grant
2011 - NASA Space Grant

LEADERSHIP EXPERIENCE

Delegate to the AMA Medical Student Section (AMA-MSS) **Jan 2019 - Present**

- Elected by peers to represent Paul L Foster School of Medicine at the AMA-MSS House of Delegates
- Regularly attend El Paso County Medical Society meetings to stay current on issues
- Draft and evaluate policy recommendations for the AMA-MSS to consider

President of Public Health Interest Group **Jan 2019 - Present**

- Organize Annual MLK Day of Service Site
- Creating Health Fair Network in El Paso community

IT and Marketing Committee Chair of Salud Sin Fronteras Clinic **Jan 2019 - Present**

- Volunteer regularly at a free clinic to help migrant farm workers in the El Paso, TX area
- Modernizing clinic technology resources and awareness campaigns in the community

Barrett, The Honors College at ASU — Tempe, AZ **Jan 2014 - May 2014**
Student Advisory Committee to develop new Student Leadership Course

Fulton Career Center at ASU — Tempe, AZ **Jan 2011 - Jan 2012**
Student Advisory Committee

VOLUNTEER EXPERIENCE

Free Clinic Volunteering **July 2017 - Present**

- Volunteer at the following El Paso free clinics: Salud Sin Fronteras, Rotacare, and the Medical Student Run Clinic
- Participate in numerous campus wide volunteer events

Sankara Eye Hospital in Bangalore, India **June 2016 - Aug 2016**

- Spent the summer volunteering at an Eye Hospital in Bangalore, India
- Served in a variety of roles ranging from translation to revamping clinic flow

Barrett, Talent Match **Aug 2011 - May 2014**
President

- Ran program for honors college students to mentor at risk youth

LANGUAGE PROFICIENCY

English - Native/First Language
Spanish - Intermediate Learner
Kannada - Receptively - Advanced, Response - Beginner, Read/Writing - Unable

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Anveshi (First) Gabriela (Middle) Guha (Last)

Address: 4601 W. Markham St., Apt 3092 (Street address)

City, State, Zip: Little Rock (City) AR (State) 72205 (Zip)

Telephone: 870-897-6047 (Day) (Evening)

Email address: AGGuha@uams.edu

Medical School: UAMS

Expected graduation: 2025

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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Signature of State Delegation Chair or State Medical Society EVP: David Wooten

Signatory's name and title (Please print): David Wooten, EVP State: ARK

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Richard P Wheeler, MD /SMW

Signatory's name and title (Please print): Richard P. Wheeler, Exec Assoc. Dean Academic Affairs

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Email: mss@ama-assn.org

Anveshi Guha

4601 W. Markham Street, Apt. 3092
Little Rock, AR, 72205
Cell: (870) 897-6047
AGGuha@uams.edu

EDUCATION

University of Arkansas for Medical Sciences College of Medicine, Little Rock, AR
MD/PhD *Anticipated 2025*

Vassar College, Poughkeepsie, NY
B.A. Neuroscience 2015

RESEARCH

Internal Medicine Department, Division of Endocrinology, UAMS 2019-present

- Researching ways to prevent and improve glucocorticoid-induced osteoporosis using *in vivo* models
- Helping identify source and function of bone formation regulators
- Working with transgenic mice, micro-computed tomography, histomorphometry, dual-energy X-ray absorptiometry, and transcriptomics

Department of Physiology and Biophysics, UAMS 2018

- Assisted Dr. Patty Wight in preparing transgenic murine model to study hPLP1 gene regulation and potential therapeutic targets for dysmyelinating disorders

Department of Neurobiology, UAMS 2018

- Assisted in Dr. Cindy Kane's project studying microglial activation in Fetal Alcohol Syndrome by performing mouse fixation, brain microdissection, and histology

Vassar College 2015

- Worked with Dr. Sarjit Kaur in studying hydrogen bonding patterns using mass spectrometry

BioStrategies LC. 2014

- Assisted in developing and improving enzyme replacement therapies for lysosomal storage disorders
- Optimized company's protein purification protocol for iduronidase
- Presented to primary investigators about forms of drug delivery
- Surveyed different stages of drug research and development

LEADERSHIP

American Medical Association

Delegate 2018-present

- Attending national conferences (I-18, A-19) to represent UAMS and Arkansas
- Increasing school-wide awareness of AMA activities and opportunities, in order to improve showing at national conferences

UAMS M1 Representative 2017-2018

- Awarded Section Involvement Grant to improve chapter's community service efforts
- Organized health fair at local schools, providing education and resources regarding nutrition and hygiene to children K-6

Arkansas Medical Society 2017-present

- Advocating to Arkansas General Assembly in the best interest of Arkansas patients, as well as medical students and practitioners
- Attending "Doctor for a Day"

UAMS Rainbow Alliance

Co-founder and steering committee member 2018-present

- Working to establish campus-wide involvement
- Collaborating with UAMS administration and local LGBT community to create educational and social events, recruit members, and spread awareness
- Developing programming focused on issues affecting Arkansas LGBT+ patients
- Student representative on LBGTQ+ Diversity, Equity, and Inclusion Subcommittee

Student Interest Group in Neurology

Communications Chair 2018-present

- Working with faculty to develop summer preceptorship covering various neuro-related disciplines
- Coordinating with campus facilities and faculty to create workshop and training opportunities, including neuro procedure simulation and neurological exam practice
- Helping organize speakers for monthly meetings, covering topics such as day-to-day neurological practice, subspecialties, telemedicine, specialized patient populations, and career counseling

M1 Representative 2017-2018

- Helped connect classmates to neurology- and neuroscience-oriented shadowing and research opportunities
- Gave lecture regarding basic knowledge and opportunities in neuro-related fields to local public schools

Outreach Coordinator 2019-present

- Working with Chancellor's office, Employee Engagement Coordinator, and the College of Medicine to present volunteer opportunities to students, improve communication with faculty preceptors, and encourage overall institutional outreach

American Physician Scientist Association
Social Chair 2019-present

- Organizing informal gatherings and activities for students in the MD/PhD program
- Improving interface between MD/PhD program students and other medical students interested in research

Treasurer of UAMS chapter 2018-2019

- Helped bring guest speakers and workshops to campus to improve training and networking opportunities for physician-scientists in-training

Graduate Student Association
MD/PhD Representative 2019-present

- Liaison between the UAMS APSA chapter and the GSA

12th St. Health and Wellness Center
Research Committee member 2018-2019

- Assisted primary investigators and student investigators in designing studies and optimizing research methods
- Peer-reviewed UAMS submissions to the Society of Student Run Free Clinics (SSRFC) conference

Camp Neuro
Co-director Summer 2018

- Helped arrange workshops, lab exercises, basic knowledge and clinical specialty lectures, and team-building activities for 20+ high schoolers during a one-week day camp
- Organized sheep brain dissection, and instructed and oversaw suturing session

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VOLUNTEERING

12th St. Health and Wellness Center

- 100+ volunteer hours; multiple independent interpreting experiences for Spanish-speaking patients

Harmony Health Clinic

- Weekend staff medical student
- Providing health screenings and helped organize booths for fall fundraiser
- Assisting in planning and volunteer recruitment for spring fundraiser and participating in the student-led performance

Community Health Fairs

- Providing blood pressure, blood sugar, and BMI screenings for underserved Hispanic population in **LULAC Health Fair**
- Providing health screening and identity-specific counseling and resources to local LGBT+ community at **Little Rock Pride**
- Promoting community health by providing health screenings, risk assessments, and counseling at accessible location for underserved patients at **Synergy Saturdays**

Fundraising Walks

- Surveying families in order to improve diagnosis for Arkansas Autism Foundation and counseled individuals with autism on local resources during annual **Walk for Autism**
- Organizing with Team UAMS for annual **Out of the Darkness** walk

Walk With A Doc

- Among the primary organizers for monthly walks to encourage community health in an environment that is open, informal, and accessible to patients

Amyotrophic Lateral Sclerosis clinic

- Working under Dr. Neil Masangkay, obtaining focused history and performing neurological exam; interacted with patients at various stages of disease progression

Neurosurgical preceptorship

- Working under Dr. Viktoras Palys, obtaining full history and performing full physical

Student National Medical Association

"Pre-Medical Summer Scholars" Advisor

- Mentored undergraduate students from minority groups underrepresented in healthcare in their premedical experiences and medical school applications
- Reviewed statements and counseled students individually on strengthening applications

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PROFESSIONAL MEMBERSHIPS

American Medical Association
Arkansas Medical Society
American Society for Bone and Mineral Research
American Association of Neurologists
American Physician-Scientist Association
American Association of Physicians of Indian Origin

AWARDS AND HONORS

Systems Pharmacology and Toxicology Fellowship, UAMS TRI 2019-present
MD/PhD Scholarship, UAMS 2017-present
Excellence in Scientific Research, Biostrategies LC 2014

Application for AMA-MSS Regional Delegate and Alternate- 2020

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Shuchita (First) Vijay (Middle) Jhaveri (Last)

Address: 1115 South Expressway 83 (Street address)

City, State, Zip: Harlingen (City) Texas (State) 78550 (Zip)

Telephone: (956)-778-4018 (Day) (956)-778-4018 (Evening)

Email address: shuchita.jhaveri01@utrgv.edu

Medical School: University of Texas Rio Grande Valley School of Medicine

Expected graduation: 2023

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: David Henkes MD

Signatory's name and title (Please print): David N. Henkes, MD, Chair, TX Delegation State: TX

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Stanley I. Fisch, MD - Associate Dean for Student Affairs

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Email: mss@ama-assn.org

SHUCHITA VIJAY JHAVERI

1115 South Expressway 83 | Harlingen, TX 78550 | 956.778.4018 | suchijhaveri@yahoo.com

EDUCATION

University of Texas Rio Grande Valley School of Medicine — Edinburg, TX
Doctor of Medicine Candidate — Jul 2019 – May 2023

Emory University Rollins School of Public Health — Atlanta, GA
Master of Public Health Candidate in Global Health — Aug 2018 – May 2020
Concentration in Sexual and Reproductive Health

Baylor College of Medicine — Houston, TX
Doctor of Medicine Candidate — Jul 2015 – Jul 2018

University of Texas Rio Grande Valley (formerly known as UT Pan American) — Edinburg, TX
Bachelor of Science in Biology — May 2015
Bachelor of Arts in English
Guerra Honors Program and Baylor Pre-Medical Honors College
Magna Cum Laude

South Texas High School for Health Professions — Mercedes, TX
Diploma in Health Sciences — May 2011
Summa Cum Laude

EXPERIENCE

Fulton County Board of Health — Atlanta, GA
Public Health Masters Practicum — Jan 2019 – Jul 2019
- Developed toolkits for vaccination management and maternal and child resilience
- Developed training presentations for toolkit integration along with surveys for toolkit evaluation

Fulton County Board of Health — Atlanta, GA
Volunteer Coordinator — Jan 2019 – May 2019
- Worked with community members and government organizations such as the CDC to prepare for Superbowl 53
- Served on the Fulton County Board of Health Steering Committee

Action Potential Learning — Houston, TX
Science Teacher/Tutor — Jan 2017 – May 2017
- Worked with students to improve science standardized test scores
- Led experiments and activities for students to better understand scientific concepts
- Collaborated with teachers to improve education within the institution

Public Health Outreach through Baylor College of Medicine — Houston, TX
Student Volunteer — Jul 2015 – May 2016
- Worked at free health clinics through OBGYN interest group and Texas Children's Hospital
- Conducted eye exams, Pap smears, pelvic exams, and child vaccinations

United States Agency for International Development (USAID) Washington, DC
Archer Fellowship Intern, Archer Alumni Board Member Jan 2015 – May 2015

- Worked in communications, media, and outreach with a focus on maternal and child health in various priority countries throughout the world
- Collaborated with programs such as Johns Hopkins's Jhpiego and Children at Risk in addition to the Maternal and Child Survival Program
- Attended various global health and public health seminars at the Capitol, the Brookings Institute, and USAID DC Office
- Enrolled in courses led by US legislators that focused on policy, advocacy, and government history
- Wrote and defended a policy proposal titled "Addressing Mental Health Injustices in the Criminal Justice System" in front of a panel of government officials

University of Texas - Pan American Study Abroad Europe
Student Jun – Jul of 2013, 2014 & 2015

- Interacted with the local people, learned about regional customs and religions, and explored local history in the following countries: Turkey, Hungary, Austria, Czech Republic, Ireland, and Northern Ireland
  - Turkey: studied and wrote a literary analysis on Zeno's ideas and paradoxes
  - Budapest, Vienna, Prague: studied and wrote an analysis of the history and impact of the holocaust with a focus on the Theresienstadt concentration camp
  - Ireland and Northern Ireland: filmed, directed, and edited a documentary about the impact of Irish culture and the legalization of same sex marriage referendum on undergraduate students of various disciplines

University of Texas - Pan American Academic Mentor Edinburg, TX
Student Mentor Aug 2013 – May 2014

- Advised students to improve their academic performance by helping create study schedules and organizing courses
- Mentored students to enhance their experiences by encouraging extracurricular activities
- Helped pre-med students with coursework and research opportunities

Baylor College of Medicine Honors Premedical Academy Houston, TX
Student Jun 2012 – Jul 2012

- Participated in a preceptorship at Ben Taub Hospital (Radiation Oncology)
- Enrolled in accelerated medical school courses

University of Texas - Pan American Learning Assistance Center Edinburg, TX
Teaching Assistant Jan 2012 – May 2012

- Taught honors statistics
- Obtained a certification in tutoring
- Worked with students one on one to improve student success rate

Valley Baptist Medical Center Harlingen, TX
Volunteer 2008 – 2011

- Assisted physicians and nurses with patient care
- Provided disaster relief after hurricane damage to the hospital
- Answered questions and concerns from patients and their families

Doc Prep Houston, TX
Student Jun 2010

- Shadowed surgeons
- Enrolled in courses in preparation for medical school
- Learned cell biology laboratory techniques
- Shadowed healthcare professionals

MD Anderson Summer Immersion Program Houston, TX
Student Jun 2009

- Learned about cancer studies and animal research
- Shadowed researchers in animal research facilities
- Shadowed healthcare professionals throughout the Texas Medical Center

LEADERSHIP

American Medical Association Edinburg, TX
Region 3 Resolution Review Committee Member Oct 2019 – Present

- Will review resolution submissions and attend meetings in preparation for upcoming national meetings

Student Outbreak Response Team (SORT) Atlanta, GA
Community Outreach Liaison Oct 2018 – Present

- Attended lectures by Subject Matter Experts from the Centers for Disease Control and Prevention and learned about CDC's pivotal role in national public health emergencies
- Partnered with emergency preparedness teams at Fulton County Board of Health to work on ongoing Super Bowl LIII preparedness activities
- Completed FEMA certifications and mental health first aid training

Title IX Hearing Board Committee Member Atlanta, GA
Emory University Sept 2018 – Present

- Selected as a student representative to serve on the Hearing Board to adjudicate alleged Title IX violations among faculty, staff and students

Baylor Student Wellness Program Houston, TX
President, Co-founder May 2017 – Jul 2018

- Led the effort to identify areas of improvement and develop solutions to improve student wellness on campus
- Helped establish a sustainable program on campus called BeWell- Student which addresses comprehensive student wellness with an emphasis on mental health, and an incentivized physical fitness program

Doctors for Change Houston, TX
Vice President, Baylor College of Medicine Chapter Jan 2016 – Jul 2018

- Focused on social health issues such as healthy eating and active living, anti-human trafficking, health policy, access to care, immigrant and refugee health, and mental health
- Helped create outreach programs that addressed the social health issues
- Participated in fundraising activities for the non-profit Doctors for Change of Houston

Texas Children's Hospital Houston, TX
Kidney Koaches Coordinator Jan 2016 – Dec 2016

- Recruited medical students to spend time with children (6 months-18 years old) in dialysis
- Helped children in dialysis with any homework and address any issues they may be experiencing while in treatment

Citizen Schools Houston, TX
Baylor College of Medicine Coordinator Jan 2016 – Dec 2016

- Organized an after-school program that brought science and medical education to underserved middle schools
- Recruited medical students to teach middle school students about the human body, and organized coursework and dissection labs
- Helped integrate the program into the Care for the Underserved track at Baylor College of Medicine

Texas Medical Association/American Medical Association Houston, TX
Vice President, Baylor College of Medicine Chapter Jan 2016 – Dec 2016
National Committee of Physician Health and Wellness

- Attended conferences around the country to further understand the role of medical students and healthcare professionals in healthcare policy
- Recruited and encouraged students to play an active role in advocacy and healthcare policy
- Attended meetings and voted on policy changes within the organization
- Helped draft policy proposal regarding concussions in high school football players

Matthew Carter Service Day Council Houston, TX
Treasurer Jan 2016 – Dec 2016

- Helped organize a day of service for all first year Baylor medical students in memory of Matthew Carter, a student who was killed while studying medicine at Baylor
- Worked closely with an elective to coordinate a day in memory of Matthew Carter and found speakers to present at the event
- Coordinated with local community service organizations to organize volunteer activities

Baylor College of Medicine Student Ambassador Houston, TX
MS1 Representative Jul 2015 – May 2016

- Encouraged students to attend Baylor College of Medicine
- Provided tours of the campus to visitors and prospective students

Student Government Association of UTPA Edinburg, TX
Health Advisory Committee and Honors Council Aug 2012 – Aug 2013

- Assessed health issues on campus and provided practical solutions
- Served as a student representative for the Guerra Honors Program

Eta Omicron Nu (HON) Edinburg, TX
Historian (2012), Vice President (2013-2015) Aug 2011 – May 2015

- Organized events to collect resources for hurricane relief efforts
- Raised funds to provide scholarships to students in need
- Recruited students into the honors program

Indian Cultural Association Edinburg, TX
Fundraising Chair Aug 2011 – Dec 2014

- Coordinated fundraising events to increase cultural awareness among students
- Organized a fair for local children to learn about world cultures

RESEARCH AND PUBLICATIONS

Emory University Rollins School of Public Health — Atlanta, GA
Masters Thesis — Aug 2019 – Present

- Research in progress: Studying the impact of immigrations and customs enforcement on the health of female immigrants

Emory University Rollins School of Public Health — Atlanta, GA
Directed Study — Aug 2019 – Present

- Research in progress: Studying the influence of religious perspectives on abortion while comparing between major religions

Johns Hopkins School of Public Health — Baltimore, Maryland
Research Fellow — Jun 2019 – Present

- Manuscript in preparation
  Title: Child Sexual Abuse as a Longitudinal Predictor of Sleep in Adulthood: Exploring the Role of Perceived Stress as a Mediator.
  Authors: **Jhaveri S**, Assini-Meytin L, Van Eck K
- Presented Research findings at the Centers for Disease Control and Prevention
- Designed and conducted study to better understand the public health significance of child sexual abuse

Emory University Rollins School of Public Health — Atlanta, GA
Co-Author — Jan 2019 – May 2019

- Studied the public health impact of community based participatory action research and co-authored a digital book chapter on photovoice.

Texas Children's Hospital — Houston, TX
Research Assistant — Aug 2016 – Jan 2017

- Analyzed outcome of various surgical procedures indicated for Wilms' Tumor
- Extracted data from medical charts to obtain and compile information regarding prognosis and procedures

University of Texas - Pan American Frank Dean Laboratory — Edinburg, TX
Honors Thesis Research — Aug 2012 – Dec 2014

- Manuscript in preparation
  Title: Effects of Diethylstilbestrol, Tamoxifen, 4-Hydroxytamoxifen, Endoxifen, and Resveratrol on Steroid Binding to the Androgen and Estrogen Receptors.
  Authors: **Jhaveri S**, Perez L, Ortiz B, Silvola C, Kotsikorou E, Dean F
- Conducted experiments to understand the biological effects of various compounds
- Tested compounds along with radioactive ligand to measure protein binding

Howard Hughes Medical Institute — Edinburg, TX
High School Research Project — Jun 2010 – Jul 2010

- Title of project: Measurement of Oxidative Stress Induced by Heavy Metals in Brassicaceae Plant Species Using Protein Carbonylation
- Conducted research to identify a potential eco-friendly solution to heavy metal pollution in soil
- Collected and analyzed data and presented findings at the Hispanic Engineering Science and Technology Week at University of Texas- Pan American (poster presentation)

SELECTED HONORS AND AWARDS

- Emory Rollins School of Public Health Best GIF Proposal Award 2018
- University of Texas- Pan American Top Honors Thesis Award 2015
- Who's Who Award 2015
- Dean's List 2011-2015
- Health Occupations Students of America: Creative Problem Solving State Finalist 2011-2012
- Pan American/Baylor Pre-medical Honors College: Early acceptance into medical school 2011
- University Scholar 2011
- AP Scholar 2011
- President's Award for Educational Achievement (Gold) 2010-2011
- President's Honor List 2009-2011

ADDITIONAL ACTIVITIES

- Methodist Surgical Corps: Assisted surgeons in exploring new medical devices and tools 2015-2017
- Choosing Healthy Eating Fresh (CHEF): Taught community member on healthy eating habits 2015-2016
- Habitat for Humanity Volunteer 2011-2014
- National Art Honors Society 2010-2011
- National Honors Society: Treasurer 2009, Vice President 2010 2008-2011
- Lead America: Healthcare Leadership Summer Program at the University of California San Diego 2008-2009
- National Technical Honors Society 2007-2011
- Health Occupation Students of America: Treasurer 2007, Historian 2009 2007-2011
- Students Against Destructive Decisions (SADD): Treasurer, helped students cope with mental health issues, and any other struggles they may be facing 2007-2011

SKILLS AND CERTIFICATIONS

- Advanced Cardiovascular Life Support (ACLS) Instructor
- Basic Life Support (BLS) Instructor
- Yoga and Pilates Instructor Certification
- Mental Health First Aid Certificate
- FEMA Certifications: IS 100, IS 200, IS 700, IS 800
- Fluent in English and Gujarati; elementary proficiency in Hindi, Spanish, French, and American Sign Language

Candidate's Diversity Statement

Shuchita Jhaveri

Please describe how you will bring diversity to the position for which you are applying.

I am fortunate to have an array of experiences under my belt that would help me contribute to diversity as regional delegate/alternate delegate. Growing up in one of the most medically underserved regions in the country, I witnessed firsthand the harrowing effects of healthcare inequality and disorderly health policy. My hometown quickly rose among the ranks with some of the highest rates of diabetes, cardiovascular disease, and cancer in the whole country. As I witnessed this snowballing of events, I knew I wanted to be a healthcare provider with an active role in health policy and advocacy. I wanted to work with underserved communities and help improve their health outcomes. It was this upbringing that inspired to pursue a public health degree along with my medical degree. Over the years, I have gained experience in public health and learned how crucial it is to integrate it with clinical medicine and health policy. I firmly believe that this viewpoint along with my experiences will bring a unique perspective to the American Medical Association. I would be absolutely honored to work with a group of diverse peers and serve as regional delegate/alternate delegate.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Justin (First) William (Middle) Magrath (Last)

Address: 4403 Elba Street (Street address)

City, State, Zip: New Orleans (City) LA (State) 70125 (Zip)

Telephone: (985) 789-7780 (Day) same (Evening)

Email address: jmagrath@tulane.edu

Medical School: Tulane University School of Medicine

Expected graduation: May 2025

AMA-MSS Region (1-7): 3

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Jeffery W. Williams State: LA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): MARC J KAHN, MD, MBA, MACP, FRCP

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Email: mss@ama-assn.org

Justin Magrath

617 Highland Ct. Mandeville, LA 70448
jmagrath@tulane.edu (985) 789-7780

Education

Tulane University School of Medicine, New Orleans, LA
MD/PhD Dual Degree, May 2025
Physician Scientist Program

The University of Alabama, Tuscaloosa, AL
Bachelor of Science in Chemical Engineering, May 2017
Minor in Computer-Based Honors, May 2017
Minor in Mathematics, May 2017
Honors College and Chemical Engineering Honors

Research

Tulane Center for Stem Cells and Regenerative Medicine

- Dr. Bruce Bunnell (2019-Present)
- Using CRISPR/Cas9 to treat Krabbe Disease

The University of Alabama Chemical Engineering Department

- Dr. Yonghyun (John) Kim's Lab (2014-2017)
- First author publication: "Salinomycin's potential to eliminate glioblastoma stem cells and treat glioblastoma multiforme," International Journal of Oncology, September 2017.
- Middle author publication: "Acidic pH with coordinated reduction of basic fibroblast growth factor maintains the glioblastoma stem cell-like phenotype *in vitro*," Journal of Bioscience and Bioengineering, May 2017.
- 2nd Place 2016 AIChE Southern Regional Conference Poster Competition
- Presented poster at 2016 Biomedical Engineering Society Annual Meeting
- Techniques: cell culture, qPCR, flow cytometry, microplate reader assays

Tulane National Primate Research Center

- Summer Fellowship Program (2015)
- Construction of a HIV-based Lentiviral Vector to Treat Krabbe Disease
- Techniques: transformation, molecular cloning, gel electrophoresis, recombinant DNA technology, transfection, transduction, magnetic sorting

Honors/Awards

Catherine J. Randall Premier Award (2017)

- Most outstanding scholar at The University of Alabama

H. Pettus Randall Jr. Computer Based Honors Scholarship (2016)

- For outstanding undergraduate research

Chemical and Biological Engineering Outstanding Senior Award (2016)

- Given to top four seniors in Chemical Engineering

Randall Outstanding Undergraduate Research Award (2015 & 2016)
Donald F. Othmer Academic Excellence Award (2015)

- Sophomore chemical engineer with highest GPA

Outstanding General Chemistry Student Award (2014)
Computer-Based Honors Outstanding Freshman Award (2014)
National Merit Scholar (2013)
Eagle Scout (2009)

Activities/ Leadership

American Medical Association (2017-present)

- **Region 3 Chair** (2019-2020)
- **Region 3 Delegate** (2019)
  - Helped organize Region 3 Conference (February 2019)
- Parliamentary Procedure Committee
  - **Chair** (I-19)
  - Vice Chair (A-19)
  - Member (I-18)
- House Coordination Standing Committee (2019-2020)
- Standing Committee on Scientific Issues Member (2018-2019)
- Resolutions Authored:
  - "Support for Universal Basic Income Pilot Studies" (I-18)
  - "Advocate for Global Carbon Pricing System" (A-19)
- Tulane Chapter Treasurer (2018)

Louisiana State Medical Society

- **Chair-Elect** (2019-2020)
- Delegate (2018, 2019)
- Legislative Chair (2018-2019)
  - Organized the writing and submission of 5 resolutions
- Authored Resolutions:
  - "Oppose Medicaid Work Requirements" (2019)
  - "Promote Physician Autonomy in Abortions" (2019)
  - "Firearm Regulation in Louisiana" (2019)

American Medical Student Association (2017-2018)

- **Chapter President** (2018)
- Navigator for ACA enrollment effort
- Organized March for Our Lives
- AMSA National Conference in Washington D.C. (2018)
  - Best Grassroots Poster on ACA enrollment effort
  - Best Chapter Award

Alabama Kayak Club (2013-2017)

- **President** (2015-2017)
- Organized and led club outings and practices, managed budget, worked with university staff
- Treasurer (2014-2015)

Diversity Statement:

My experience with the ACA enrollment effort and education path as a MD/PhD student will both help me bring diversity to the MSS.

As a first-year medical student, I got involved with 504HeatlhNet, a local New Orleans non-profit that strives to improve health access for the city population. Through 504HealthNet, I became a Certified Application Counselor and traveled to various locations throughout New Orleans to assist people in signing up for health insurance through the Marketplace Exchange. This experience put me face-to-face with a population that we do not often come into contact with as a medical student. I not only learned how the exchange works, but also about the hurdles Americans face in the enrollment process. As a second-year student, I collaborated with the leaders of 504HealthNet to improve this year's enrollment strategy. The knowledge I have gained through this process will help me inform other AMA members about how the exchanges work and what alterations could be made to increase their effectiveness.

As a MD/PhD student, I can help to bring the perspective of a scientist to the AMA-MSS. I have 2 publications from undergrad and will be starting research full-time this summer. This experience will enable me to be bring insight about the scientific process, especially as it pertains to gene therapy, my area of research. I believe gene therapy will bring about important ethical questions in the near future that the AMA will need to answer. My work in this field will allow me to serve as a resource for other members looking to better understand the methods and potential implications of gene therapy.

Together, my unique background and interest in policy will allow me to be an effective and helpful leader of the MSS.

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- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Dory (First) Hannah (Middle) Askins (Last)

Address: 108 Arlington Avenue (Street address)

City, State, Zip: Greenville (City) SC (State) 29601 (Zip)

Telephone: 864- 704-5461 (Day) (Evening)

Email address: daskins@email.sc.edu

Medical School: University of South Carolina School of Medicine Green

Expected graduation: May 2021

AMA-MSS Region (1-7): 4

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Gregory Taracidis MA State: SC
SC AMA Delegation chair

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Paul Catalena MD Associate Dean for Students

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: [redacted]

Dorothy (Dory) Askins

108 Arlington Avenue ● Greenville, South Carolina 29601
Phone: 864-704-5461 ● E-Mail: daskins@g.clemson.edu

EDUCATION

University of South Carolina School of Medicine Greenville, Greenville, SC
07/17—5/21
Doctor of Medicine Candidate
Involvement: South Carolina Medical Association (SCMA)/American Medical Association (AMA) Interest Group President, Medical Student Association Class Co-President, OB/GYN Interest Group Secretary, CMDA Outreach Chair, Vice-Chair SCMA Medical Student Section Governing Council, Delegate for South Carolina to the AMA, AMA House Coordination Committee Member and Team Lead, Kaplan Student Brand Ambassador, Greenville County Medical Society Medical Student Representative, Tigers on Call Panel Speaker, Clemson Clinical Applications and Medical Practices Class Panel Speaker, AMPAC Member, AMPAC Campaign School 2018 Graduate, SCMedPAC Member, SCMA Medical Student Section Chair, Clemson Undergraduate Research Engagement (CURE) Team Lead, Clemson University Alpha Chi Omega New Member Education Advisor

. SCMA Health Policy Fellow Summer 2018, Prague Selective Program Summer 2018

Clemson University, Calhoun Honors College, Clemson, SC
08/13-05/17
Bachelor of Biological Sciences Graduate – GPA – 3.51

- Honors: Blue Key Honors Society, Golden Key Honors Society, Alpha Epsilon Delta (AED) Pre-Health Honors Fraternity, Mortar Board Honors Society, Order of Omega
- Leadership:
  - Undergraduate Student Government: University Services Chairwoman, IT Student Advisory Board Chairwoman, Senate Secretary (Executive Board), Freshman Council, Freshman Council Mentor, Student Senator, Cabinet Outreach Committee Member
    - Worked with other representatives to formulate student laws
  - Alpha Chi Omega Sorority: Freshman Class Facilitator, Recruitment Round Chair, Recruitment Committee Member
    - Assisted in making decisions for the recruitment process and helped orientate new members
  - Residence Hall Association Community Council: Clemson House Community Advocate

        - Representative in the residence hall association, made sure that residents were involved in the Clemson community
    - New Student and Family Services: Welcome Leader and Welcome Coordinator
        - Orientated new students to Clemson's campus
- Activities: Foundation for the International Medical Relief of Children (FIMRC), Student Alumni Association, Fellowship of Christian Athletes (FCA)

University of Aberdeen, Aberdeen, Scotland
01/15-05/15
Bachelor of Biological Sciences Candidate

WORK EXPERIENCE

Legislative Intern for US Senator Tim Scott, *Washington, DC*
07/15
- Assisted with projects dealing with trade, press, and healthcare, answered constituent phone calls

Greenville Health System's Medical Experience Academy: Student, Chief Intern, and Chief Advisor, *Greenville, SC*
- Assisted in organizing, planning, and leading sessions

Poll Manager and Assistant Clerk for the 2012, 2014 Elections 11/12, 06/14, 11/14, 11/16, 11/18
- Assisted in confirming that the polling place was following all laws and running the voting process efficiently

In-Home Aid for a Disabled Child
10/12-6/13
- Assisted with exercises and care of a wheelchair-bound child

Clemson UPIC Internship with the Associate VP of Health Research
- Assisted with health research in relevant areas of student health and in the collaboration between Clemson University and Greenville Health System

Clemson Student Worker for the Office of Student Affairs
- Assisted Clemson's Dean of Students in solving issues related to student affairs

SERVICE

Clemson Free Medical Clinic, Village at Pelham Hospital
08/13-08/15, 01/11-01/14
- Assisted physicians by taking notes, picking up prescriptions, and helping patients to their treatment rooms

PUBLICATIONS

Boyk, M., McIntyre, B., Kouser, A., Anzola, Z., Schwiekert, M., Askins, D., & Pilcher, J. J. (2017, April). *Smart & savvy students: Life hacks.* Electronic poster presentation at Clemson University 12th Annual Focus on Creative Inquiry Symposium, Clemson, SC.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST..
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: James (First) Alan (Middle) Cooper (Last)

Address: 2000 SW 16th St. Apt 118 (Street address)

City, State, Zip: Gainesville (City) FL (State) 32608 (Zip)

Telephone: (423) 817-5013 (Day) (Evening)

Email address: james.cooper@ufl.edu

Medical School: University of Florida College of Medicine

Expected graduation: Spring 2022

AMA-MSS Region (1-7): 4

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): **Corey Howard, MD, FACP Chair, FMA Delegation, Immediate past president** State: **Florida**

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): _____ State: _____

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Patrick Duff M.D. 10/2/19

Signatory's name and title (Please print): Patrick Duff, M.D. Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☐ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☐ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☐ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☐ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

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Email: mss@ama-assn.org

Jimmy Cooper

MD Candidate | University of Florida College of Medicine | (423) 817-5013 | james.cooper@ufl.edu

CORE COMPETENCIES

- Active leadership of peers and colleagues
- Compassionate patient care
- Organization and planning skills
- Public speaking
- Self-motivated/highly adaptable
- Resolution writing and review

PROFESSIONAL EXPERIENCE

- AMA-MSS Community Service Committee Member (2019-present)
- University of Florida AMA-MSS Delegate and Alternate Delegate (2019-2020; 2018-2019)
    - Region 4 Policy Committee – Member (Fall 2019)
    - University of Florida AMA Policy Committee – Chair (Fall 2019)
- UF Florida Medical Association Delegate and Alternate Delegate (2019-2020; 2018-2019)
    - FMA Legislative Committee member (2018-2019)

EDUCATION

Bachelor of Musical Arts – Vanderbilt University, Nashville, TN
Major – Musical Arts
Academic focus – Pre-medical course work
Other training – Political science, public speaking, health law

Medical Doctorate (pending) – University of Florida College of Medicine, Gainesville, FL

COMMUNITY INVOLVEMENT

- Boy Scouts of America Eagle Scout Recipient (2013)
- Volunteer at UF Equal Access Clinic (2018-present)
- Counselor at Camp Boggy Creek children's camp (summer 2019)
- Organized/Directed Vanderbilt Percussion Group concert at Vanderbilt Children's Hospital
- Vanderbilt Student Volunteers for Science (2016-2018)
    - Lead weekly science lessons and experiments for elementary school classrooms
- Harmonies for the Elderly (2015 – 2018)
    - Monthly concerts for patients in assisted living facilities

RESEARCH

- Quality Improvement Research in UF Department of Cardiology – (pending 2019)
- SyBBURE research group (Vanderbilt 2016-2017)
    - Creative thinking exercises, idea generation workshops, guided group "Thinktank" projects, independent research assistance
- Burnette Lab (Vanderbilt 2016-2017)
    - Cellular forces, genetic heart disease, super-resolution microscopy, image analysis
    - *Taneja et al. "Precise tuning of cortical contractility regulates mechanical equilibrium during cell division" submitted to Cell Press*

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Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

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- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Lauren (First) Ashley (Middle) Forbes (Last)

Address: 2110 E. Fairmount Ave (Street address)

City, State, Zip: Baltimore (City) Maryland (State) 21231 (Zip)

Telephone: 252-333-9114 (Day) _____ (Evening)

Email address: laforbesunc@gmail.com

Medical School: Brody School of Medicine at East Carolina University

Expected graduation: May 2021

AMA-MSS Region (1-7): 4

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

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Signature of State Delegation Chair or State Medical Society EVP: Shawn M Scott, Senior VP

Signatory's name and title (Please print): Shawn M. Scott, Senior VP for Robert Seligson, EVP/CEO State: NC

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Susan Schmidt MS Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying. I was born and bred in an underserved, rural part of my state before choosing to attend a medical school that was distinctly created to serve that population. I am always honored to represent and share the rural healthcare experience with my AMA colleagues so we can best serve the underserved.

8. Demographics. The following questions are optional:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☒ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☒ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

Would you describe yourself as having a disability/being differently-abled?
☐ Yes ☒ No
Explain, if desired:

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Email: mss@ama-assn.org

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Please indicate your decision below:

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ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

LAUREN ASHLEY FORBES

252.333.9114 · laforbes@jhu.edu · 2110 E Fairmount Ave, Baltimore, MD 21231

EDUCATION

Johns Hopkins Bloomberg School of Public Health Class of 2020
M.P.H. Candidate. Baltimore, MD

Brody School of Medicine at East Carolina University Class of 2021
M.D. Candidate. Greenville, NC

University of North Carolina at Chapel Hill Class of 2014
B.S. in Biology, Minor in Chemistry. Chapel Hill, NC.

CERTIFICATIONS

Advanced Care Life Support
American Heart Association Apr 2018
Basic Life Support
American Heart Association Apr 2018
Stop the Bleed
Stop the Bleeding Coalition Aug 2018
Orientation for New Clinical Research Personnel
NC Translational and Clinical Sciences Institute, Chapel Hill, NC. Aug - Sep 2014
Research Phlebotomy Basics
UNC School of Medicine, Chapel Hill, NC. Aug 2014

SCHOLARSHIPS

William K. Wassink Medical Scholarship Recipient 2017-2020
Awarded annually by The Elizabeth City Foundation to a permanent resident of Camden or Pasquotank County who is enrolled in medical school and exhibits satisfactory academic progress.

Dr. Loretta M. Kopelman Endowed Scholarship Recipient 2018-2019
The Kopelman fund provides a need-based scholarship for a Brody SOM student who has demonstrated initiative in women's and leadership issues in medicine.

Tiana Nicole Williams Memorial Endowment Recipient 2017-2018
Endowment established to fund research and community service projects submitted by Brody SOM students that address the issue of domestic violence. Requires over 200 service hours and report upon completion of the project.
Focus: *Incorporating trauma and abuse training as part of Brody SOM's four-year clinical skills curriculum.*

Captain Ernest W. Fox Perpetual Scholarship Recipient 2011-2022
Awarded to active duty enlisted personnel and officers, civilian employees, and their dependents to provide and education or training benefit to personnel at the Coast Guard Aircraft Repair and Supply Center located in Elizabeth City, NC.

HONORS

Graduation Junior Marshall May 2019
Brody SOM. Junior Marshalls are selected based on rank and invited to participate in graduation ceremonies

Summer Program for Future Doctors Scholar May - Jul 2015
Brody SOM. Finished the program ranked 6 out of 23 non-matriculating students plus 4 matriculating students and "highly recommended for admission".

Dean's List Recipient Fall 2013, Spring 2014
UNC. A minimum of a 3.500 semester grade point with no grade lower than a C if enrolled in at least 12 hours of letter-grade credit.

Buckley Public Service Scholar 2011 - 2014
UNC. Program model that incorporates at least 300 hours of public service, one service-learning course, four approved skills trainings, an orientation session, a senior reflection activity, and a minimum cumulative GPA of 3.0.

PROFESSIONAL SOCIETIES

American Congress of Obstetricians and Gynecologists May 2017 - Present
Student Member.
Brody SOM OB/GYN Interest Group Vice President Apr 2017 - May 2018

American Medical Association Aug 2016 - Present
Student Member, including Pitt County Medical Society and NC Medical Society.
Medical Student Section Committee on Long Range Planning Aug 2018 – Present
Brody SOM MSS Delegate Interim '17, Interim '18, Annual '19
Brody SOM MSS Alternate Delegate Interim '19

LAUREN ASHLEY FORBES

252.333.9114 · laforbes@jhu.edu

MSS House Coordination Committee Interim '19
"Is There a Vaccine for Burnout?" Program Host Interim '18, Annual '19
MSS Hospitality Committee Interim '17

American Medical Women's Association Aug 2016 - Present
Student Member.
Brody SOM AMWA Co-president May 2017 - May 2018

UNC Network for Research Professionals 2014 - 2016
Member.

Carolina Firsts 2010 - 2014
Organization for first-generation college students at UNC.

Alpha Epsilon Delta 2010 - 2014
National Health Pre-professional Honor Society at UNC.

Beta Beta Beta 2012 –2014
National Biological Honor Society at UNC.

RESEARCH

Research Distinction Track Scholar Aug 2017 - Present
Brody SOM. Greenville, NC.
This program prepares and supports students in the pursuit of clinical, basic science, and translational research to characterize disease, factors influencing health, and potential therapies.
Focus: *The association between opioid exposure during pregnancy with fetal metabolites and neonatal outcomes.*
Focus: *Influence of maternal aerobic exercise at levels recommended by public health guidelines on fetal heart cardiac function and outflow.*

Summer Scholars Research Program May - Aug 2017
Brody SOM. Greenville, NC.
This program allows rising second-year medical students to spend eight weeks during the summer performing medical research, under the direction of clinical and basic science faculty at BSOM.
Focus: *Liquid chromatography/mass spectroscopy method development for identifying drugs of abuse in the umbilical cord matrix.*

Clinical Research Associate Sep 2015 - Jul 2016
UNC Department of Endocrinology, Chapel Hill, NC
Diabetes Care Center: Clinical Research
-- Worked closely with clinical research coordinators to execute all aspects of industry- or NIH-funded clinical studies for Type 1 or Type 2 diabetes mellitus
--Primary coordinator for T1D Exchange Clinic Registry study
--Responsibilities: recruited potential study participants via clinic, phone, email and explain study purpose, design and procedures; collected/processed/shipped patient blood and/or urine specimen; improve patient retention strategies; instituted excess/expired medical supply donation program; trained incoming research assistants

Program Manager Jun 2014 - Jan 2016
UNC Department of Ophthalmology, Chapel Hill, NC
North Carolina Diabetic Retinopathy Telemedicine Network
--Coordinated the full-scale dissemination and implementation of an innovative retinal tele-screening program that reduced eye care access barriers for diabetics across NC
--Responsibilities: collected/managed clinical metadata; coordinated/managed grant contracts and amendments; engaged stakeholders and built partnerships through meetings, educational outreach, and policy briefs; analyzed metadata and composition/submission of abstracts, presentations, and manuscripts; conducted geographic information system-mapping for final program evaluation

SERVICE

Public Health Interest Group Feb 2017 - Present
Brody SOM.
Co-founder, Vice President of Advocacy Feb 2017 - Jan 2018

Medical Student Council Apr 2017 - Mar 2019

LAUREN ASHLEY FORBES

252.333.9114 · laforbes@jhu.edu

Brody SOM. Attend monthly meetings with student leaders to represent and serve the medical student body.

Brody Beautification Committee May 2017 - Present
Formal Committee Co-chair Aug 2017 - Apr 2019
Class Representative May 2017 - Apr 2019

Greenville Community Shelter Clinic Nov 2016 - Apr 2018
Brody SOM. 1st and 2nd year medical student volunteer at student-run medical clinic.

Pitt County Care Clinic Nov 2016 - Apr 2018
Brody SOM. 1st and 2nd year medical student volunteer at student-run medical clinic.

Camp Needle in the Pines Camp Counselor Jul 2017
Brody SOM Department of Pediatrics, Greenville, NC.
--Camp Counselfor for 8 13-15 year-old girls during a week-long summer camp for children and adolescents with Type 1 diabetes.
--Coordinated with camp staff regarding insulin dosing, blood glucose checks, camp activities, and child life functions
--Awarded the "Rising Star Award" voted on by camp staff and counselors for being a first-year counselor and rising above the typical duties of the position.

Birth Doula 2015 - 2016
NC Women's Hospital, Chapel Hill, NC.
--Provided physical, emotional, informational and advocacy support to women and their partners/families during both birth and postpartum periods.
--Attended 16 hours of classroom instruction and 2 mentored births at NC Women's Hospital for training

Maternity Center Representative 2011 - 2016
NC Women's Hospital, Chapel Hill, NC.
--Conducted tours of Labor and Delivery and Maternity Care Center units to expectant mothers and their support person(s).
-- Hosted Ready, Set, Baby appointments to inform expectant mothers and their support person(s) on the basics of delivery at UNC, newborn care, and breastfeeding; training included breastfeeding course taught by UNC Doulas.
--Operated Women's Hospital Information Center desk and associated programs.

CURRICULUM DEVELOPMENT & TEACHING

Liaison Committee on Medical Education Site Visit
Brody SOM.
Committee on Organizational Leadership and Resources Sep 2019 - Present

Medical Education Course & Clerkship Review
Brody SOM.
Health System Ethics Course Bi-annual Review Nov 2019
Internal Medicine Clerkship Bi-annual Review Oct 2019
M1 Curriculum Improvement Task Force Nov 2016 - May 2017

Peer Assisted Study Session Facilitator Dec 2016 - May 2017
Brody SOM. P.A.S.S. Group Facilitator for Immunology, Microbiology, and Genetics courses.

PUBLICATIONS

In Progress Manuscripts:
Effects of Maternal Aerobic Exercise on Fetal Ultrasound and ECHO Cardiac Function Measurements. May L**,** McDonald S, **Forbes LA**, Jones B, Moyer C, Livingston J, Newton E, Strickland D, Isler C, Haven K, Steed D, Hartman R, Applegate S, Kuehn D, May L.

Quantitative Method for Opioids and Stimulants in Umbilical Cords Using Liquid Chromatography/Mass Spectrometry. Mamillapalli S, Smith-Joyner A, **Forbes L**, Rushing B, Strom C, Danell A, May L, Kuehn D, Ravisankar S, Kew K.

Peer Reviewed Manuscripts:
Jani PD, **Forbes L**, Choudhury A, Preisser J, Viera A, Garg S. Evaluation of Diabetic Retinal Screening and Factors for Ophthalmology Referral in a Telemedicine Network. *JAMA Ophthalmol.* 2017 Jul

1;135(7):706-714. PMCID: PMC5710198.

Jani PD, **Forbes L**, McDaniel P, Viera A, Garg S. Geographic Information Systems Mapping of Diabetic Retinopathy in an Ocular Telemedicine Network. *JAMA Ophthalmol.* 2017 Jul 1;135(7):715-721. PMCID: PMC5710206

Mwanza JC, Grover DS, Budenz DL, Herndon LW, Nolan W, Whiteside-de Vos J, Hay-Smith G, Bandi JR, Bhansali KA, **Forbes LA**, Feuer WJ, Barton K. A Comparison of Cup-to-Disc Ratio Estimates by Fundus Biomicroscopy and Stereoscopic Optic Disc Photography in the Tema Eye Survey. *Eye*. 2017 Aug;31(8):1184-1190. PMCID: PMC5558222.

Policy:
H-420.949: Support for Rooming-In of Neonatal Abstinence Syndrome Patients with Their Parents. Approved Res 525 for adoption by the AMA House of Delegates at Annual 2019. Chicago, IL. June, 2019.

245.022MSS: Support for Rooming-In of Neonatal Abstinence Syndrome Patients with Their Parents. Approved MSS Res 01 for adoption by the AMA-MSS at Interim 2018. National Harbour, MD. November, 2018.

Non-peer Reviewed Online Publication:
Closer Look: American Diabetes Association 76th Scientific Sessions Full Report. *Close Concerns*. Published online July, 2017. Accessible with subscription login at www.closeconcerns.com.

ABSTRACTS

Forbes LA, Gautam A, Tran N, Trivedi M, Skrabal JR. *Integration of Interpersonal Violence Competencies into a Medical School Curriculum.* Poster presentation at the American Medical Association EXPO Research Symposium, San Diego, CA, 2019.

Forbes LA, Jones R, Strickland D, Isler C, Haven K, Steed D, Hartman R, Applegate S, Kelley G, Chasan-Taber L, McDonald S, Kuehn D, May L. Influence of maternal aerobic exercise on fetal right-sided heart function: a randomized controlled trial. *American College of Obstetrics and Gynecology.* 2019 J an;220(1):S94. Poster presentation at the Society for Maternal Fetal Medicine's 39th Annual Pregnancy Meeting, Las Vegas, NV. February, 2019.

Forbes L, Kattan G, Nelson K, de Vente J. *Implementing the BabyPASS (Patient Antenatal Support System) to Promote and Optimize Record Transmission between a County Health Department and a Tertiary-Care Academic Center.* Poster presentation at High Value Practice Academic Alliance National Research and Education Symposium, Baltimore, MD. September, 2018.

Forbes LA, Mamillapalli S, Rushing BR, Smith-Joyner AM, Strom CJ, Kuehn D, Kew K, Ravisankar S. *Quantitative Method for Drugs of Abuse in Umbilical Cords using Liquid Chromatography/Mass Spectroscopy.* Poster presented at Mayo Clinic Metabolomics Symposium, Rochester, MN. October, 2 017. **Awarded 2nd place**.

Jani PD, **Forbes LA**. *GIS-Mapping of Diabetic Retinopathy in North Carolina.* Poster presentation at NCAFP Annual Winter Family Physicians Weekend, Asheville, NC. December, 2016.

Jani PD, **Forbes LA**, Garg S. *Improving access to eye care through the North Carolina Diabetic Retinopathy Telemedicine Network.* Poster presented at Preventive Medicine 2016 of American College of Preventive Medicine, Washington, DC. March, 2016.

Triolo G, Vinod K, Sola del Valle D, Monsalve P, **Forbes LA**, Feuer WJ, Mwanza JC, Budenz DL, Vazquez LE. *Ganglion Cell – Inner Plexiform Layer or Retinal Nerve Fiber Layer: which one is affected first in Early Glaucoma*? Poster presented at the annual meeting of the American Glaucoma Society, Fort Lauderdale, FL. March, 2016.

Vazquez LE, Mwanza JC, Triolo G, Monsalve P, Burke SP, Reyes-Capo DP, Aranguren L, **Forbes LA**, Feuer WJ, Parrish RK, Gedde SJ, Budenz DL. *Analysis of arcade retinal nerve fiber bundle volume has greater diagnostic accuracy than nerve fiber layer thickness for detecting glaucoma.* Poster presented at the annual meeting of the American Glaucoma Society, Fort Lauderdale, FL. March, 2016.

Forbes L, Mwanza JC, Warren JL, Budenz DL. *Residual and dynamic range of retinal nerve fiber layer thickness in glaucoma: comparison of three OCT devices.* Poster presented at the annual meeting of the

LAUREN ASHLEY FORBES

252.333.9114 · laforbes@jhu.edu

Association for Research in Vision and Ophthalmology, Denver, CO. May, 2015.

PRESENTATIONS *Invited Oral Presentations:*

"PASSPORT: Patient Antenatal Support System to Promote and Optimize Record Transmission"
Presented as Grand Rounds to ECU Department of Obstetrics and Gynecology at Vidant Medical Center in Greenville, North Carolina. June, 2017.

"The North Carolina Diabetic Retinopathy Telemedicine Network: A Hitchhiker's Guide to the (Retinal) Galaxy"
Presented to primary care health care providers and clinic administrators the I3 Population Health Collaborative Spring Conference in Greenville, North Carolina. April, 2015.
Presented as a course for ophthalmic photographers and those interested in ocular imaging and/or telemedicine at the Ophthalmic Photographers' Society Annual Meeting, part of the American Academy of Ophthalmology Annual Meeting. November, 2015.
Presented as continuing education webinar for Ophthalmic Photographers' Society. June, 2016.

Interviews:

Brown D. (2014, September 11). College Diabetes Network*: Highlighting sweet CDN grads* [Blog post]. Retrieved from https://collegediabetesnetwork.org/content/highlighting-sweet-cdn-grads.

emailed 9/24

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Amber		Gautam
	First	Middle	Last
Address:	4713 Haleytree Ct		
	Street address		
City, State, Zip:	Raleigh	NC	27606
	City	State	Zip
Telephone:	919-757-5468	919-757-5468	
	Day	Evening	
Email address:	amber.gautam@gmail.com		
Medical School:	Brody School of Medicine at East Carolina University		
Expected graduation:	2021		
AMA-MSS Region (1-7):	4		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**
2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Shawn M Scott

Signatory's name and title (Please print): Shawn Scott, Senior VP State: NC
for Robert W. Seligson, EVP/CEO

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: [signature]

Signatory's name and title (Please print): Susan Summidt MD, Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. **Candidate's Diversity Statement.** Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions are optional:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☑ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☑ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

Would you describe yourself as having a disability/being differently-abled?
☐ Yes ☑ No
Explain, if desired:

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****Optional Release to External Organization Positions** – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☑ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

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Email: mss@ama-assn.org

AMBER GAUTAM

amber.gautam@gmail.com | 919.757.5468 | 4713 Haleytree Ct Raleigh, NC 27606

EDUCATION & HONORS

East Carolina University Brody School of Medicine, Greenville, NC *Expected May 2021*
M.D. Candidate

- *Health System Transformation and Leadership Distinction Track* (10 students): AMA Accelerating Change in Medical Education program promoting patient-centered care, patient safety, quality improvement, population health, and interprofessional team-based care

Harvard T.H. Chan School of Public Health, Boston, MA *Expected May 2020*
M.P.H. Candidate

The University of North Carolina at Chapel Hill Gillings School of Global Public Health, Chapel Hill, NC *Graduated May 2015*
B.S. Public Health – Nutrition | Minors in Chemistry and Spanish for the Medical Professions | Cumulative GPA: 3.58/4.00

- *Colonel Robinson Scholar:* merit-based scholarship with summer enrichment opportunities
- *Honors Carolina Program* (9.0% of class)
- *Order of the Grail-Valkyries:* honors society for contributing to the academic climate through scholarship, leadership, and service
- *Buckley Public Service Scholar:* criteria include 300 service hours, service-learning courses, skills trainings, and critical reflection
- *Carolina Research Scholar:* criteria include research-intensive courses and official presentation of research

EMPLOYMENT & INTERNSHIP EXPERIENCE

Epic Systems Corporation, Madison, WI *September 2015 – April 2016*
Implementation Consultant

- Completed training in *Clinical Documentation,* the Epic electronic health record software application designed for inpatient nurses
- Coordinated implementation of software at the Children's Hospital of Eastern Ontario (160+ beds) through analysis of client-specific clinician workflow by working directly with client-appointed "Superusers" from the major clinical, billing, and revenue departments
- Collaborated with 10+ internal teams for other Epic software applications to optimize interdependent functionality

Clinical Skills Development, UNC School of Medicine *August 2013 – May 2014*
Patient Facilitator Intern

- Served as a standardized patient for case-based learning in the clinical simulation laboratory for ~120 first year medical students
- Provided feedback based on effective patient-doctor communication, physical examination technique, and compassionate rapport

Kyetume Community Based Health Care Program, Uganda *Summer 2013*
Summer Intern (Advocates for Grassroots Development in Uganda within Campus Y Center for Social Justice)

- Received $4,000+ Hogan Fellowship grant to conduct research on nutrition, dietary habits, and physical activity in rural Uganda
- Collected quantitative data on body fat composition, BMI, nutritional deficiencies; conducted qualitative surveys on cooking practices
- Initiated adolescent nutrition intervention at 3 schools for 50+ students: designed nutrition curriculum and gardening skills training

Global Brigades, Honduras *Summer 2012*
Medical Brigade Intern

- Collaborated with dental, public health, water, and microfinance departments to improve quality and efficiency of the holistic intervention model for world's largest student-led global health and sustainable development non-profit organization
- Administered community-needs assessments and redesigned patient health education session to include preventive screenings, STIs, family planning, and chronic diseases
- Independently streamlined a protocol for safe and sustainable medication adherence for patients with multiple chronic conditions

RESEARCH & PRESENTATIONS

UNC Center for Health Promotion and Disease Prevention, Gillings School of Global Public Health *May 2014 – May 2015*
Research Assistant in Nutrition Intervention and Policy (P.I. Dr. Alice Ammerman: Center Director)

- Primary projects: Hearth Healthy Lenoir (HHL) and Carolina Heart Alliance Networking for Greater Equity (CHANGE)
- Created GIS map of U.S. Census data with social determinants of cardiovascular (CVD) risk in Hertford County, NC
- Administered participant interviews for lifestyle, genetics, and restaurant intervention to address CVD risk in Lenoir County, NC
- Collected data measurements for BMI and mobility for a study on obesity in minority women
- Assisted in additional projects related to Supplement Nutrition Assistance Program, healthier school lunch programs, health disparities, Orange County food council, and more

Department of Nutrition, Gillings School of Global Public Health *May 2013 – May 2014*
Research Assistant in Nutrition Epidemiology (P.I. Dr. Elizabeth Mayer-Davis: Department Chair)

- Project: Search Study for Diabetes in Youth (largest database of incidence, prevalence, complications of childhood diabetes in the US)
- Maintained databases of clinical care teams for participants, and morbidity and mortality
- Developed interventions for type I&II diabetes self-management systems for high-risk youth in the Eastern Band of Cherokee Indians

Oral Presentations

- **Gautam, Amber;** Kumar, Sangeetha; Morris, Lisa; Jost, Geneva. *ScienceDays—Integrating Innovation: Transitioning to Social Justice.* NC Civic Engagement Institute Student Conference, Raleigh, NC, November 8, 2014.

Poster Acceptances

- **Gautam, Amber;** Trivedi, Mansi; Forbes, Lauren; Tran, Nga; Skrabal, Ryan. *Para-curricular Integration of Interpersonal Violence and Abuse into a Medical Curriculum.* AMA EXPO Research Symposium, San Diego, CA, November 15, 2019.
- **Gautam, Amber;** Staplefoote-Boynton, Lynette. *Quality Payment Program Strategies in Eastern NC.* NC Medical Society Leadership Education Advocacy Discovery Health Care Conference, Raleigh, NC, October 19, 2018.
- **Gautam, Amber;** Trivedi, Mansi; Forbes, Lauren; Tran, Nga; Skrabal, Ryan. *Integration of a Trauma-Informed Medical Education Curriculum.* Association of American Medical Colleges National Conference, Orlando, FL, April 28-May 1, 2018.
- McDuffie, LaShawn, RN, MSN; Potter, Leann, RN, MSN; Gurganus, Kelsey, RN; Bryant, Joyce, RN, LPN; **Gautam, Amber.** *Continuous Monitoring of Pain Assessment and Management for Patients Receiving Radiation Therapy.* ECU Annual Quality Improvement Symposium, Greenville, NC, January 31, 2018.
- **Gautam, Amber;** Thatcher, Esther, Ph.D. *Mapping Social Determinants of Cardiovascular Risk in Rural NC.* UNC Annual Research Symposium, Chapel Hill, NC, April 15, 2015.
- **Gautam, Amber.** *Pesticide Exposure in Migrant Farmworkers in NC—The Unheard Voices of our Agricultural System.* Carolina Center for Public Service Annual Awards Showcase, Chapel Hill, NC, April 15, 2013.

Case Competitions

Quadruple Aim Student Innovation Contest, 1st place, ECU Annual Quality Improvement Symposium, Greenville, NC, January 31, 2018.

PROFESSIONAL ORGANIZATIONS

American Medical Women's Association, *Co-President of Brody Chapter* *April 2017 – Present*

- Organize professional development and community outreach opportunities for medical students that promote the cause of women and other gender minorities in medicine

North Carolina Medical Society, *Student Representative* *August 2017 – Present*

- In process of re-establishing Medical Student Section as a forum to develop, critique, and inform healthcare policy
- Attended NC Medical Society Merging Medicine and Management Conference 2017

Doctors for America, *National Member* *August 2017 – Present*

- Organize coalitions of medical students to advocate for their schools and communities by increasing voting and contacting legislators
- Attended National Leadership Conference 2018

American Medical Association-Medical Student Section *August 2016 – Present*

Brody School of Medicine (SOM) Delegate – Annual 2017, Interim 2017, Annual 2018, Annual 2019, Interim 2019

- Elected to represent Brody SOM to serve as a voting delegate to accept or challenge proposed AMA healthcare policies

House of Delegates Coordinating Committee – Interim 2017, Annual 2018, Annual 2019, Interim 2019

- Selected to serve as a policy analyst to review, edit, critique, formulate a position on policies that affect medical students nationwide
- Attend policy hearings to note opinions and advise the Medical Student Caucus how to strategize pushing forward policies of interest

Vice Chair of Reference Committee – Interim 2019

- Selected to lead efforts to create recommendations based on consolidated critiques of policy proposals, prioritize proposals to reflect the values of the AMA and MSS, and facilitate a forum for thoughtful analysis of proposals

Institute for Healthcare Improvement, *Brody Chapter Member* *August 2016 – Present*

- Facilitate inter-professional learning experiences among 80+ medical, physician assistant, dental, and nursing students with the aim of fostering collaboration, team-building, and quality improvement

Student National Medical Association, *Brody Chapter Member* *August 2016 – Present*

- Mentor at afterschool program of 30+ young underrepresented girls in elementary and middle school targeted at building coping mechanisms, developing healthy relationships, and encouraging healthy lifestyle habits

American College of Obstetrics and Gynecology, *National & State Member* *October 2018 – Present*

- Recipient of 2019 John Gibbons Medical Student Award honoring passion and dedication to women's healthcare and advocacy

American Academy for Family Physicians, *National & State Member* *August 2016 – Present*

- Attended NC AAFP Annual Conference in 2016 & 2017, and Annual Family Medicine Day in 2017

ACTIVITIES & LEADERSHIP

NC Perinatal Outreach Coordinator Program, *Program Assistant* *July 2018 – Present*

- Block grant through NC DHHS to improve maternal and neonatal morbidity and mortality through reduction of unintended pregnancies
- Develop protocol for immediate postpartum long-acting reversible contraception (LARC) placement at Vidant Labor & Delivery
- Optimize education on immediate postpartum LARC placement for Vidant Ob-Gyn residents to minimize expulsion rates

Harvard Chan Forum for Politically Engaged Progressives, *Co-Founder & VP of Finance* *August 2019 – Present*

- Create a space to engage the public health community in political discourse related to policies and platforms of election candidates

Arts in Public Health, *Co-Founder & Officer* *August 2019 – Present*

- Connect the Harvard public health community with local artistic projects and explore the use of art as a vessel for social change

Greenville Community Shelter Clinic, *Referral Coordinator* *April 2017 – Present*

- Coordinate continued care for 100+ patients at a free, student-run clinic for the local underserved population in Greenville, NC

- Develop formal referral program for patients to be seen at the local Health Dept for family planning services
- Operate as Clinic Director to oversee 80+ volunteer medical students, public health students, pharmacy residents, social workers, and attending physicians to ensure free prescriptions and referrals are correctly filled and free testing is properly administered

Partners of Integrative Medicine, *Vice President* *April 2017 – Present*
- In process of developing Mind-Body Wellness Curriculum for each incoming medical student class and integrating Compassion Training with the goal of addressing burnout during pre-clinical and clinical years

Brody SOM Public Health Interest Group, *Founder & President* *December 2016 – Present*
- Create a space for 60+ student members to explore the role of clinicians in public health through advocacy, health policy, disease prevention, community outreach, etc. and facilitating learning opportunities regarding the impact of public health on patient outcomes
- Design a student elective opportunity in conjunction with NC DHHS entitled *"Health Policy and Public Health for Clinicians"*
- Collaborate with religious studies faculty to plan the inaugural *Symposium on Religion & Public Health* at ECU in April 2018

Tiana Nicole Williams Memorial Endowment, *2017 Fellow* *April 2017 – April 2018*
- Received $1000 grant to develop and implement longitudinal curriculum for medical students at Brody SOM that addresses competencies in domestic violence, trauma, and abuse from social and professional standpoints
- Spearheaded annual multi-day series for 40+ students about sexual assault education, clinical approaches, and community stakeholders

Brody School of Medicine Administration *August 2016 – July 2019*

Liaison Committee on Medical Education Academic Environment Committee
- Participate in institutional self-study of scholarship, diversity and pipeline activities, and faculty development
- Identify opportunities for continuous quality improvement in these areas

Diversity Task Force
- Selected by Dean of Brody SOM to provide feedback on promotion of diversity within curriculum and student environment

Examination Policy and Procedures Quality Improvement Committee
- Mapped out current examination processes that result in undesirable testing outcomes for course directors and students
- Created standardized procedures and protocols for effective administration of examinations by the Office of Medical Education

Curriculum Improvement Task Force
- Appointed by Medical Student Council Curriculum Representative to provide feedback and synthesize suggestions for improvement of course content, content delivery, and knowledge assessments with Basic Science Course Directors

Associate Dean of Admissions Selection Committee
- Review candidate credentials, conduct student-led interviews, write formal evaluations

ScienceDays, *Co-Founder & Co-President (UNC Chapter), National Board Member* *January 2013 – May 2015*
- Launched afterschool mentor program targeting local students in grades 4-5 who are underrepresented in STEM fields
- Received *Robert E. Bryan Social Innovation Fellowship* for $1,500 grant and resources to develop entrepreneurial community project
- Delegated mentoring, community outreach, and lesson planning committees to design and execute inquiry-based science enrichment
- Recruited over 70 members, established 3 school partners, hosted 13 community events, and created 36 lesson plans
- Redesigned national intervention model to innovatively and effectively address the educational achievement gap seen in STEM

UNC Admissions Ambassador, *Selection Committee* *August 2013 – May 2015*
- Selected to represent UNC at recruitment events, panels, and campus tours for prospective students

Carolina United, *Counselor* *August 2013 – August 2014*
- Designed and led sessions on Social Norms and Assumptions; Sexual Violence; and Religion, Faith, Spirituality at a retreat for 60+ students to critically explore diversity introspectively and through interpersonal dialogue
- Co-led small group discussions of 10 students for reflection and identity development

Carolina Nutrition Digest, *Social Media Editor* *May 2012 – May 2013*
- Established official blog of the Nutrition Coalition in Gillings School of Global Public Health to promote awareness of nutrition in the news, food culture, food industry, nutrition in public health, and research findings
- Created and managed Wordpress and Facebook pages, and contributed guest blog posts

UNC Service-Learning Initiative, *Alternative Break Trip Leader* *October 2012 – May 2014*
- Planned and co-led service-learning trip for 10 students focused on Latino communities with educational and service opportunities, as well as critical reflection
- Designed and taught weekly recitation lessons for *Critical Approaches to Service-Learning* course for 10 trip participants focused on theories of public service, farmworker rights, immigration policy, higher education, health disparities, and personal development

Student Health Action Coalition (Chapel Hill), *Spanish Interpreter & Operational Efficiency Taskforce* *August 2012 – May 2015*
- Facilitated patient-clinician dialogue to improve quality of care at nation's oldest non-profit student-run clinic
- Collaborated for QI project with teams from medicine, public health, social work, pharmacy, physical therapy, and administration
- Implemented *Lean Six Sigma* process, resulted in 10% increase in number of patients seen and 30-minute decrease in patient wait time

Alpha Epsilon Delta Pre-Health Honor Society, *Job Shadowing Coordinator* *August 2012 – May 2015*
- Established new clinical observation program for 100+ members with placements in 30+ hospital departments and 6+ specialty degrees
- Helped plan philanthropy event *Arts for Hearts* that raised $1000+ for UNC Cardiology and Building for Tomorrow (NGO)

UNC Global Brigades, *Campus Chairperson* *October 2011 – May 2014*

- Oversaw and facilitated collaboration among trip leaders for medical, dental, public health, water, microfinance, human rights brigades
- Initiated pre- and post-brigade trip education modules and evaluation metrics to improve 80+ brigaders' understanding of holistic, sustainable, empowering, culturally competent interventions for addressing global health and economic disparities

SKILLS

Languages: Intermediate fluency in Hindi and Spanish (reading, writing, speaking)
Training: Basic Life Support, Advanced Cardiac Life Support, Stop the Bleed – Bleeding Control Basics (Medical Student trainer)
Computer Software: Experience in MATLAB, R, Maple
Hobbies: Ukulele, volunteering at the local farmer's market

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- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Daniel (First) Carter (Middle) Lee (Last)

Address: 206 Cypress Cove Court (Street address)

City, State, Zip: Greenville (City) SC (State) 29611 (Zip)

Telephone: 804-894-1103 (Day) same as day (Evening)

Email address: Dclee@email.sc.edu

Medical School: University of South Carolina School of Medicine - Greenville

Expected graduation: 2022

AMA-MSS Region (1-7): 4

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Gregory Tarasidis, MD, SC Delegation Chair State: SC

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Paul Catalana MD Associate Dean Student Affairs

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7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☒ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☒ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☒ No
Explain, if desired:

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Email: mss@ama-assn.org

Daniel Lee

Dclee@email.sc.edu | (804)-894-1103

Permanent Address:
206 Cypress Cove Court
Greenville, SC 29611

Education

University of South Carolina School of Medicine – Greenville
MD Candidate for the Class of 2022

University of South Carolina; Columbia, SC
Obtained a Bachelor of Science in Biology as a Capstone Fellow with a minor in Neuroscience
GPA: 4.0; President's List (x6), Dean's List (x6), Recipient of the Phi Beta Kappa Award

Experience

Research

University of South Carolina School of Medicine - Greenville – January 2019-Present
Greenville, SC
-Collected data and composed a paper on endocrinological outcomes on resection of pituitary adenomas (awaiting submission)
-Accepted abstract "A Comparison of Blood Based Testing to Tissue Sampling for the Detection of Mutations in Non-Small Cell Lung Cancer" at ECTSS 2019(regional)
-Submitted publication as first author "*Acanthamoeba spp.* and *Balamuthia mandrillaris* leading to fatal granulomatous amebic encephalitis" (Pending review)
-Collected data on prevalence and outcomes of Klebsiella species infections at Prisma Health
University of South Carolina School of Medicine - October 2014-December 2017
Columbia, SC
-Awarded the Magellan's Apprentice Scholarship (2014) and the Magellan Scholar Grant (2016) for my research plan
-Collected data on rat behavior and neuronal activation in experiments revolving around Post Traumatic Stress Disorder
-Presented the poster "Behavioral Stress Responses of Rats in the Presence of Predator Odor:Freezing Behavior as an Indicator of PTSD-like Responses" at SYNAPSE 2015 (regional) and Discover USC 2015
-Presented the poster "Activation of Hypothalamic Orexin Neurons During Fear Extinction" at SYNAPSE 2017 and gave an oral presentation at Discover USC 2017
-Attended the Society for Neuroscience Annual Conference in 2017 to learn more about modern neuroscience research
University of Vermont College of Medicine – May 2017-August 2017
Burlington, VT
-NIH sponsored fellowship at the University of Vermont with a focus on clinical research.
-Attended lectures that provided an in-depth overview of modern neuroscience research
-Used brain imaging, cognitive testing, extensive assessment of family environment and culture to understand development from ages 10-20.
-Analyzed the effects of nicotinic antagonists on prodromal schizophrenia
-Shadowed physicians in the field to see applications of modern clinical research in action.
–Collaborated with various labs in order to move forward in a large developmental study on children.

Daniel Lee
Dclee@email.sc.edu | (804)-894-1103

-Presented "The Effects of a Nicotinic Antagonist on Attention in Prodromal Schizophrenia" at multiple symposiums

Volunteer Work

Faces and Voices of Recovery – September 2018-Present
Greenville, SC
-Worked as a phone recovery coach to set goals and aid victims of addiction during their recovery
-Maintained a working relationship with patients by communicating on a weekly basis

Personal Touch – Palmetto Health Baptist - September 2016-December 2017
Columbia, SC
-Assisted nurses in providing physical or emotional support to patients
-Volunteered in high stress environments like the Emergency Room and learned how to adapt to such situations
-Restocked supplies, cleaned rooms, transported patients, and performed other duties to ensure cycling of patients in and out of the hospital.
-Engaged with patients to ensure their needs were met appropriately and quickly
-Developed the ability to alleviate the fear or anxiety of patients during their stay

Study Abroad – March 2016-August 2016
Nagasaki, Japan
-Attended Nagasaki University of Foreign Studies and participated in classes taught exclusively in Japanese
-Lived with a Japanese family in order to experience Japanese culture in its truest form
-Tackled an ever-changing environment by thinking on my feet
-Created a blog to document my journey in Japan so that others could have the chance to see Japan through me

Activities

American Medical Association (AMA)/South Carolina Medical Association (SCMA) (Designated Delegate) – July 2018-Present
-Member of the House Coordination Committee (HCC) for I-19
-Member of the Medical Student Section Reference Committee for I-19
-Attended the Medical Student Section of I-18 and A-19 in order to promote and learn about policy to change the future of medicine
-Worked on and helped edit resolutions coming from the southeastern region
-Member of the Policy Committee at USCSOM – Greenville
-Authored and promoted the adoption of "Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities" in the SCMA HOD
-Authored and promoted the adoption of "Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities" in the AMA-MSS. Awaiting debate in AMA HOD.
-Authored and promoted the adoption of "E-Cigarette Use in Indoor Public Spaces" in the SCMA HOD

Skills

-Proficient in Microsoft Word, PowerPoint, Excel, Prism, Neurolucida
-Certified Basic EMT
-Conversational proficiency in Japanese

Daniel Lee

Dclee@email.sc.edu | (804)-894-1103

Diversity Statement

Growing up in a single-parent family encompassed my whole childhood. It had many ups and downs, but as a young adult, I have come to reflect on the vast differences I saw between my mother and father. I lived with my mother who worked a steady job and provided for me on her own for most of my life. Meanwhile, my father was impoverished and often went to jail where I visited him on multiple occasions. In a way, I am glad that my mother and father are so glaringly different. Despite their life choices and flaws, I still care for them and would do anything to help them. Furthermore, it gave me the ability to appreciate and understand people that have varying backgrounds and experiences that are unique to them. Looking back at my childhood, I think my upbringing has taught me to appreciate peoples' differences and approach them with an open mind. With those experiences guiding me, the regional delegates are tasked with determining whether proposed policy is appropriate to enshrine as national AMA policy. I'm certain that there will be internal debate and I welcome all viewpoints on that matter in hopes that we, as a section, can come together and form the best opinion on each matter.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Tristan	Michael	Mackey
	First	Middle	Last
Address:	25 River St., Apt. 438		
	Street address		
City, State, Zip:	Greenville	SC	29601
	City	State	Zip
Telephone:	803-246-9689		
	Day	Evening	

Email address: tmmackey@email.sc.edu

Medical School: University of South Carolina School of Medicine Greenville

Expected graduation: 2022

AMA-MSS Region (1-7): 4

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Gregory Tsarnidis State: SC

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print):_____State: _____

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Paul Catalanotti MD Assistant Dean of Students

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☑ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☑ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☑ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☑ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Tristan Mackey
Curriculum Vitae

Personal Data

25 River St; Apt. 438, Greenville, SC, 29601
803-246-9689
tmmackey@email.sc.edu

Education

University of South Carolina School of Medicine, Greenville – Greenville, SC
July 2018-Present
Doctor of Medicine
Expected Graduation: May 2022

University of South Carolina –Columbia, SC
August 2014-May 2018
Bachelor of Science in Public Health, Summa Cum Laude
Spanish Minor

Honors and Awards

M1 Academic Excellence Award July 2019
- Awarded to the students with the 3 highest cumulative averages during their M1 year

University of South Carolina President's List August 2014-May 2018
- Awarded for having a 4.0 GPA for the semester; achieved 8 semesters

Arnold School of Public Health Dean's List August 2014-May 2018
- Awarded for having a 3.5 or higher GPA for the semester; achieved 8 semesters

Graduation with Leadership Distinction in Community Service May 2018
- Earned by completing 305 service hours, taking classes relative to community health, preparing an e-portfolio, and presenting on my project
- Link to e-portfolio: https://carolinatman95.wixsite.com/tristanmackeygld

Capstone Scholar and Fellow August 2014-May 2018
- Recognizes students who were high academic achievers in high school and provides them with leadership and self-development throughout college
- Fellow status is awarded to Capstone scholars who complete additional requirements beyond those expected by the program

University of South Carolina Outstanding Student Volunteer April 2018
- Awarded to a student who has made an outstanding contribution to the community and university through service

Presidential Volunteer Service Award, Bronze Level April 2018
- Awarded for completing 100 community service hours within a year

Edna A. Halkyard Scholarship August 2014
- Merit based scholarship awarded to freshmen students
- 2-year scholarship

Palmetto Fellows Scholar May 2014
- Designated by scoring a 1,200 or higher in the SAT, having a 3.5 or higher high school GPA, and being in the top 6 percent of the high school class
- 4-year scholarship

Sentinel Health Scholarship May 2014
- Merit based; awarded to graduating seniors from Kershaw or Lancaster counties
- 4-year scholarship

Service and Leadership

Region 4 Policy and Resolutions Chair June 2019-Present
- Facilitated the resolution writing process for the entire region and assisted authors in crafting well-written policy
- Strategized with authors at national meetings to ensure the passage of their resolutions

Region 4 Substitute Alternate Delegate June 2019
- Served as an alternate delegate for Region 4 as needed for the Annual meeting
- Voted as a delegate and wrote testimony for various resolutions
- Evaluated resolutions and testified on behalf of the MSS for resolutions during the Reference Committee on Amendments to Constitution and Bylaws

SC Medical Association (SCMA) Student Fellow February 2019-Present
- Served as a liaison between the medical school and the state medical association
- Designed and implemented a project to increase medical students' interest in SCMA and advocacy
- Attended quarterly meetings with SCMA staff in order to plan activities for the organization

American Academy of Neurology SIGN Chapter Founder February 2019-Present

- Connected students with information and resources from the AAN on how to pursue a career in neurology
- Networked with physicians and organized monthly meetings for other students to learn about neurology

American Association of Neurological Surgeons Chapter President February 2019-Present

- Organized meetings with neurosurgeons at the hospital in order to afford fellow medical students the opportunity to learn about this specialty
- Disseminated information from the AANS to the students of the medical school

Neuroscience Interest Group, Founding Leader February 2019-Present

- Assisted in the planning and founding an interest group for students who are interested in neuroscience
- Networked with physicians and planned meetings for students to gain more information about careers in neurology and neurosurgery

Greenville Free Medical Clinic Class Representative January 2019-Present

- Served as a liaison between staff at the free medical clinic and students at the medical school
- Assisted in scheduling students for volunteering at the clinic
- Planned and marketed outreach events to raise awareness for the clinic

Ronald McDonald House Volunteer January 2019- Present

- Maintained cleanliness of house for guest who were staying there at the time
- Assisted staff in answering phone calls and greeting visitors at the front desk

Greenville Free Medical Clinic Volunteer January 2019-Present

- Interacted with patients by taking vital signs and gathering pertinent patient history
- Assisted clinic staff in maintaining the flow of patients from the waiting room and into the exam rooms

USC-School of Medicine, Greenville AMA Alternate Delegate January-June 2019

- Represented the interest of the medical school's chapter at state and national meetings of the SCMA/AMA House of Delegates

Health Outreach Initiative Volunteer December 2018-Present

- Instructed high school students in what it means to pursue a career in healthcare, while also offering practical advice on how to go about reaching their own career goals

AMA Region 4 Liaison to the AMA Foundation November 2018-Present

- Coordinated with the AMA foundation to share information concerning scholarships and grants with the entirety of Region 4

Peer Writing and Communications Mentor August 2017-May 2018

- Facilitated training sessions
- Ensured that 14 fellow tutors were able to complete their jobs in an efficient manner
- Provided guidance and mentorship to new tutors

Harvest Hope Food Bank– Emergency Food Pantry Volunteer July 2016-May 2018

- 113 hours
- Served clients by stocking food pantry and preparing food orders
- Managed supply levels in the food pantry
- Trained fellow volunteers

Palmetto Health Baptist – Personal Touch Volunteer July 2016-May 2018

- 182 hours
- Assisted nursing staff in providing patient care by transporting patients, cleaning rooms and bed, and interacting with patients to ensure their needs were met

Kershaw Area Resource Exchange –Food Pantry Volunteer May-December 2017

- 26 hours
- Served clients by stocking food pantry and preparing food orders

Organic Chemistry II Teaching Assistant January 2017-May 2017

- Recorded attendance and graded quizzes for a class of 100 students
- Led weekly tutoring sessions for students who needed assistance
- Facilitated weekly recitation sessions outside of normal class time

Shandon College Ministry Freshmen Mentor August 2016-May 2017

- Led weekly group discussions for approximately 6-7 students
- Provided guidance for freshmen during their transition to college

The Free Medical Clinic – Medical Volunteer April 2015-November 2016

- 48 hours
- Collected patient histories and recorded vitals

Dominican Republic Public Health Mission Trip March 4th-12th 2016

- 30 hours
- Engaged with residents of a leprosy community and provided assistance as needed
- Provided necessary volunteer resources to a disability facility

English Program for Internationals Conversation Partner September-December 2014

- Conversed weekly for an hour with an international student who was learning English

Committees

AMA-MSS Reference Committee May-June 2019
- Worked with fellow medical students to evaluate and form final recommendations for resolutions that were considered at the Annual AMA-MSS meeting for 2019

South Carolina Medical Association Resolution Review Committee March 2019
- Established and served on a committee to evaluate draft resolutions for the MSS of the SCMA
- Organized reviewers, created review assignments, and ensured authors were given timely feedback on all resolutions

House of Delegates Coordination Committee January 2019-Present
- Evaluated and offered feedback to authors concerning their resolutions
- Prepared the medical student section's stance on resolutions in preparation for the House of Delegates meeting

SCMA/AMA School Chapter Executive Board November 2018-Present
- Worked with fellow board members to plan and facilitate chapter activities throughout the academic year

AMA Region 4 Policy Committee November 2018-Present
- Evaluated resolutions and guided region authors through the authorship process of the American Medical Association
- Assisted in updating the Resolution Writing guide for Region 4

USCSOMG AMA Policy Committee, Chair August 2018-Present
- Authored and evaluated resolution submissions for AMA meetings

Presentations

University of South Carolina Discovery Day – Columbia, SC May 2018
Observing Determinants of Health Through Community Service
- Poster presentation at annual USC Discovery Day
- Presented community service project that was completed at Harvest Hope food bank and discussed what my time there had allowed me to learn about the determinants of health within in a community

Publications

Peer Reviewed Resolutions Accepted as AMA-MSS Policy
- **Tristan Mackey,** Haritha Pavuluri, Rachel Michelle Shugart, Anuradha Kanaparthi, Rachana Raghupathy, and Hiba Saifuddin. 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. Submitted to American Medical Association Annual Meeting 2019: June 2019

- Haritha Pavuluri, **Tristan Mackey,** Baillie Bronner, Ellena Popova, and Haidn Foster**.** Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems Submitted to American Medical Association Annual Meeting 2019: June 2019
- **Tristan Mackey**, Rishi Thaker, and Haritha Pavuluri. Supporting the use of Mobile Integrated Health Care and Community Paramedicine in addressing the primary care shortage. Submitted to American Medical Association Interim Meeting 2018: November 2018
- **Tristan Mackey** and Haritha Pavuluri. Utilizing Food Insecurity Screenings in the Emergency Medical Setting to Identify at Risk Individuals. Submitted to American Medical Association Interim Meeting 2018: November 2018

Peer Reviewed Resolutions Accepted as South Carolina Medical Association Policy

- Margaret Oliver, Shakti Naidoo, Haritha Pavuluri, **Tristan Mackey,** Harry Rockower, and Jill Prier. Opposing Sexual Orientation Change Therapy. Submitted to South Carolina Medical Association Annual Meeting 2019: April 2019
- **Tristan Mackey,** Haritha Pavuluri Kayla Schilling, and Dory Askins. Increasing Awareness Concerning Domestic Violence and Referrals. Submitted to South Carolina Association Annual Meeting 2019: April 2019
- **Tristan Mackey**, Daniel Lee, Maggie Oliver, and Eliza Hardy. E-Cigarette Use in Indoor Public Spaces. Submitted to South Carolina Association Annual Meeting 2019: April 2019

Peer Reviewed Resolutions Adopted as Reaffirmation to Policy

- Haritha Pavuluri and **Tristan Mackey.** Addressing Breast Cancer Disparities in African American Women. Submitted to American Medical Association Interim Meeting 2018: November 2018

Editorial Positions

American Medical Student Research Journal Reviewer December 2018-Present

- Analyzed research manuscripts and offered advice for improvements to the authors in order to produce a final publication

Professional Societies

American Academy of Neurology February 2019-Present

American Association of Neurological Surgeons January 2019-Present

American Medical Association Political Action Committee November 2018-Present

College of Neurological Surgeons November 2018-Present

American College of Surgeons November 2018-Present

Christian Medical and Dental Association August 2018-Present

American Medical Association August 2018-Present

South Carolina Medical Association August 2018-Present

Phi Beta Kappa Honor Society April 2017-Present

Alpha Epsilon Delta Honor Society October 2016-Present

Work Experience

Kaplan USMLE- Greenville, SC

Student Brand Ambassador April 2019-Present

- Represented Kaplan and their products by marketing on social media and serving as a liaison for their products on campus

Palmetto Health Richland-Columbia, SC

Centralized Transport-Patient Transporter May 2017-June 2018

- Served as an integral member of the patient care process by moving patients from their rooms to areas of the hospital where they would receive diagnostic procedures or care

University of South Carolina Student Success Center – Columbia, SC

Peer Writing and Communications Tutor August 2015-May 2018

- Facilitated in the development of writing skills for undergraduates that brought papers to the Student Success Center and helped them through the writing process
- Peer leadership role that offered professional development and training

Certifications

Nationally Registered Emergency Medical Technician October 2018-Present

American Heart Association Basic Life Support/ CPR/ AED July 2018-Present

Conferences

American Medical Association Interim Meeting November 8th-10th 2018

AMA Medical Student Region and Advocacy Conference March 7th-9th, 2019

South Carolina Medical Association Annual Meeting April 25th-28th, 2019

American Medical Association Annual Meeting June 6th-12th, 2019

SCMA Annual Leadership Symposium August 3rd, 2019

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Ian	Kris	Motie
	First	Middle	Last
Address:	251 Calliope Street		
	Street address		
City, State, Zip:	Ocoee	Florida	34761
	City	State	Zip
Telephone:	407-590-6234	Same	
	Day	Evening	
Email address:	ikm12@med.fsu.edu		
Medical School:	Florida State University College of Medicine		
Expected graduation:	May 2021		
AMA-MSS Region (1-7):	4		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): **Corey Howard, MD, FACP, FMNM, FAARM** State: **FL**

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Joan Younger Meek

Signatory's name and title (Please print): Joan Younger Meek, MD; Orlando Regional Campus Dean

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☒ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☒ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☒ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☒ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

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Email: mss@ama-assn.org

Ian Motie

251 Calliope Street
Ocoee, FL 34761
(407) 590-6234
ikm12@med.fsu.edu

Education

M.D., Florida State University College of Medicine (FSU COM), Tallahassee, FL — 2017-Present

B.S. in Biological Sciences (magna cum laude), Florida State University (FSU), Tallahassee, FL — 2012-2014

A.A. in General Studies, Valencia College, Orlando, FL — 2010-2012

Honors and Awards

Summer Research Fellowship Grant, FSU COM — 2018

Honors Diploma, Valencia College — 2012

Professional Memberships and Activities

American Medical Association (AMA) — 2017-Present

- Region IV Alternate Delegate — 2018
- Region IV Advocacy/Policy Chair, AMA — 2018-2019
- FSU COM Delegate, AMA Annual & Interim Conference — 2018-2019
- Medical Advocacy & Region Conference — 2018
  - Advocated for/against legislation on Capitol Hill

Florida Medical Association (FMA) — 2017-Present

- Advocacy & Legislative Visitation Day — 2018
  - Advocated for/against legislation at the Florida Capitol

Leadership

American Medical Association (AMA) — 2018

- Advocacy/Policy Chair, Region IV Medical Student Section
  - Serve as a resource to members of the AMA-Medical Student Section
  - Encourage resolution writing among region members while supporting and empowering authors
- Chapter Treasurer, FSU — 2017-2018

Florida Medical Association (FMA)

- Political Action Committee, Medical Student Representative — 2019
- Committee on Legislation Vice Chair, FMA Medical Student Section — 2019
- Policy and Resolution Committee Vice Chair, FMA Medical Student Section — 2018

Cover the Uninsured Week

- Executive Director
  - Developed a weeklong educational series examining what it means to lack sufficient health coverage in the U.S.
  - Created committees composed of medical students to facilitate the success of these events
  - Planned a community health screening to reach medically underserved populations

Work Experience

Scribe, Dr. Gideon G. Lewis — 2016-2017
Winter Park, FL

Medical Assistant and Front Desk Management, Dr. Shahid Samy — 2014-2017
Florida Lung Specialists, PA
Ocoee, FL

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST..
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Samantha	Marie	Pavlock
	First	Middle	Last
Address:	400 Hayden Rd. Apt 147		
	Street address		
City, State, Zip:	Tallahassee	FL	32304
	City	State	Zip
Telephone:	(561) 935-7764	same	
	Day	Evening	
Email address:	smp09j@med.fsu.edu		
Medical School:	Florida State University College of Medicine		
Expected graduation:	2022		
AMA-MSS Region (1-7):	4		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): **Corey Howard, MD, FACP Chair, FMA Delegation** State: **FL**

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Robert J. Campbell, M.D. Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions are optional:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☒ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☒ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

Would you describe yourself as having a disability/being differently-abled?
☐ Yes ☒ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☐ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Curriculum Vitae

Samantha Pavlock
400 Hayden Road, Apt 147, Tallahassee, FL 32304
Phone: (561) 935-7764 • E-Mail: smp09j@med.fsu.edu

Education

The Florida State University College of Medicine Tallahassee, FL — May 2020

Ph.D. Candidate, Biomedical Sciences

Mentors: Pradeep Bhide, Ph.D. & Deirdre McCarthy, B.S.

- Studying the effects of chemotherapy on cognitive behavior, hippocampal neurogenesis and neuroinflammation in a mouse model

The Florida State University College of Medicine Tallahassee, FL — May 2022

M.D. Candidate

M1 and M2 years completed (2018)

The Florida State University Tallahassee, FL — May 2015

Bachelor of Science Degree in Psychology; Minors: Chemistry & Biological Sciences

Medical & Research

Art in STEM Competition Tallahassee, FL — April 2019

Graduate Women in Science (GWIS), Florida State University *Contestant*

- Submitted laser confocal microscopy image of BrdU+ neuronal cells in the dentate gyrus of the hippocampus, a technique used to quantify changes in neurogenesis in a mouse model

FSU College of Medicine, Biomedical Sciences Department Tallahassee, FL — May 2017- August 2017

Pradeep Bhide, Ph.D. & Deirdre McCarthy, B.S. *Summer Research Fellow*

- Studying the effects of cyclophosphamide on cognitive behavior in a mouse model
- Seeking to understand the neurological mechanisms underlying "chemo brain" seen in breast cancer patients undergoing chemotherapy treatment
- Current Ph.D. graduate student (2018)

Red Hills Surgery Center Tallahassee, FL — October 2016- March 2017

Joseph Soto, M.D. *Physician Shadowing*

- Gained familiarity with the otolaryngology (ENT) field
- Observed ear, nose and throat surgeries

Jupiter Medical Center & Jupiter Outpatient Surgery Center Jupiter, FL — November 2015- April 2016

Luis Raul Arroyo, M.D. *Physician Shadowing*

- Observed patient consultations, physical examinations and surgical procedures

FSU College of Medicine, Biomedical Sciences Department Tallahassee, FL — August 2013- May 2015

Mohamed Kabbaj, Ph.D. *Undergraduate Research Assistant*

- Graduate mentor: Katherine Wright, Ph.D.
- Special focus: cocaine addiction & optogenetics
- Preclinical laboratory research procedures and protocols
- Worked with animal subjects to study neurobiological consequences of addiction
- Developed proficiency in protein sequencing and purification techniques

Tallahassee Plastic Surgery Clinic Tallahassee, FL May 2012- August 2014

Alfredo Paredes, M.D. *Physician Shadowing*

- Observed patient consultations, in-office procedures and operations on site
- Provided face-to-face support for breast cancer patients during physical examinations

Adolescent & Pediatric Medical Center Tallahassee, FL April 2012- August 2012

Lionel Henry, M.D. *Physician Shadowing*

- Gained familiarity with pediatric medicine
- Distinguished the significance of developmental care through various stages of childhood

Renaissance Obstetrics & Gynecology Tallahassee, FL January 2012- May 2012

Alfredo Nova, M.D. *Physician Shadowing*

- Developed familiarity with gynecology and obstetrics
- Recognized the bridge between medicine and mental health

Florida State University First Responder Medical Unit Tallahassee, FL August 2012- January 2014

Certified First Responder *(300+ hours)*

- Practiced emergency medicine and hands-on patient care
- Provided university medical response for daily proceedings, special events and sporting games

Service

Smitten with Kittens Animal Rescue Tallahassee, FL January 2019- Present

- Foster for abandoned and feral neonatal kittens

NoleMed Undergraduate Panel Tallahassee, FL January 2019

- Offered advice to FSU undergraduates interested in medical school

Women in Math, Science & Engineering Tallahassee, FL January 2019

- Gave tour of lab and career advice to support the development of women in STEM fields at FSU

Kate Sullivan Elementary School Tallahassee, FL November 2018

- Volunteered with elementary children during the school science carnival
- Helped elementary children extract DNA from bananas

AMWA Region 4 Regional Conference Tallahassee, FL October 2018

- Taught undergraduate students suturing techniques in a clinical skills workshop

Students Interested in Global Health (SIGH) Medical Mission Trip Managua, Nicaragua March 2017

- Assisted in providing medical care to over 500+ patients in a rural setting

The Kearney Center Health Screening Event Tallahassee, FL November 2016

- Provided blood pressure checks to homeless patients with FSU Cares

Migrant Farm Worker Health Fair Quincy, FL October 2016

- Provided blood pressure checks to migrant farm workers with FSU Cares

Be the Match Bone Marrow Drive Tallahassee, FL October 2016

- Helped register members of the FSU Marching Chief's as bone marrow donors

Wings for Women Jupiter, FL April 2016

- Bartended event to raise money for contraceptive methods to donate to women in Uganda

Florida State University Dance Marathon Tallahassee, FL 2013

- Danced for 26-hrs to raise money for UF Health Shands Children's Hospital

Camp Boggy Creek Eustis, FL 2012, 2013, 2013

- Helped integrate families with children suffering from similar medical conditions during a weekend-long retreat

- Camp counselor to families with children suffering from cardiac disease, rheumatic disease blood disorders, immunodeficiency illnesses and kidney disease

Big Bend Hospice Tree of Remembrance Tallahassee, FL 2012, 2013

- Sold Christmas ornaments to the local community to raise money for the Big Bend Hospice center

Florida State University Relay for Life Tallahassee, FL 2011, 2012, 2013

Walked the FSU track for 4 hours to raise money for the American Cancer Society

Ironman Florida Triathlon Panama City Beach, FL November 2012

- *First Responder*, assisted doctors and nurses in evaluating and triaging 200+ patients
- Administered emergency medical attention and relief to suffering athletes

Jupiter Medical Center Jupiter, FL 2007-2010

- *Emergency Room & Gastrointestinal Lab Volunteer*
- Facilitated emergency room staff with patient registry and transport (300+ hours)
- Recognized each member of the medical team is valuable in providing proper patient care

Work

Assistant to M.D. Lake Worth, FL January 2016- May 2016

Medical Scribe

- Responsible for documentation of the key elements of a patient's medical record
- Responsible for construction of a patient's HPI and ROS healthcare charts, utilizing the SOAP method
- Gained knowledge of medical terminology, medical abbreviations, medications, laboratory and imaging techniques, common chief complaints, and pertinent symptoms

Triatomic Environmental, Inc. Jupiter, FL August 2006- May 2014

Marketing Assistant

- Responsible for managing imports and organizing account income data with Microsoft Excel
- Calculated financial estimates and developed company presentations

Leadership & Teaching

Council on Medical Education, Science, & Public Health Florida Medical Association (FMA) July 2019- Present

- Medical student representative on the Council of Medical Education which is responsible for providing guidance to the FMA Board of Governors on issues relating to medical education
- The council serves at the FMA's liaison with the Council of Florida Medical School Deans and works closely with the medical schools on public policy matters

FSU College of Medicine MSS Delegate American Medical Association (AMA) June 2019 – Present

- Represent FSU College of Medicine at AMA annual and interim health policy meetings
- Voted on AMA policy issues at the AMA MSS annual meeting in Chicago, IL

Biomedical Sciences Retreat Planning Committee FSU College of Medicine June 2019- Present

- Student-run committee planning retreat for incoming Biomedical Sciences Ph.D. students

Undergraduate Mentor Florida State University April 2019-Present

- Mentoring Dominique Zito, an undergraduate student, who is completing a directed-individual study (DIS) studying the effects of chemotherapy and anti-inflammatory

Committee on Legislation and Advocacy (COLA) Florida Medical Association (FMA) February 2019- Present

- Student-run committee designed to facilitate legislative efforts between Florida medical schools

treatment on hippocampal neuroinflammation via microglia activation

Biomedical Sciences Student Government Association (SGA) FSU College of Medicine August 2018- Present

Treasurer

- Responsible for financial transactions; managing receipts and disbursement of funds
- Proficient in generating purchase orders and conference requests

Medical School Student Mentor FSU College of Medicine August 2017- Present

- Mentor to 1st year medical students with their transition into medical school, continuing throughout their duration in medical school
- Currently mentoring Diana Benedetti (class of 2021) and Kendall Hale (class of 2022)

Summer Research Fellowship Mentor FSU College of Medicine May 2019- August 2019

- Mentored a first-year medical student, Eammon Byrnes, who completed a 10-week summer research fellowship investigating the effects of chemotherapy and anti-inflammatory treatment on hippocampal neurogenesis

Florida Alternate Delegate AMA Annual Meeting of the House of Delegates June 2019

- Served as an alternate delegate representing the AMA medical student section for the state of Florida
- Voted on AMA policy issues at the AMA House of Delegates annual meeting in Chicago, IL

Campaign Liaison for Vice Speaker AMA Annual Meeting of the House of Delegates June 2019

- Served on Dr. Corey Howard's campaign for Vice Speaker of the AMA
- Responsible for conveying medical student views on every aspect of the campaign trail
- Represented Dr. Howard during specialty society interviews

Biomedical Sciences Research Techniques Class FSU College of Medicine November 2018

- Instructor in first year Biomedical Sciences Ph.D. candidates research techniques course
- Taught graduate students perfusion techniques and microdissection organ dissections

Summer Research Fellowship Mentor FSU College of Medicine June 2018-August 2018

- Mentored a first-year medical student, Anisha Kesarwani, for a 10-week project investigating the effects of anti-inflammatory treatment during ongoing chemotherapy on cognitive behavior

Independent Self Analysis (ISA) Task Force FSU College of Medicine November 2017- March 2018

- Student-run committee designed to facilitate the LCME reaccreditation process
- Construction of 100 question-survey that accurately depicted all reaccreditation areas of interest
- Distribution to students, analysis of results and interpretation relay to faculty

Surgery & Anesthesiology Interest Group FSU College of Medicine August 2016- December 2017

Women in Surgery Subcommittee Founder & President

- Founded the women in surgery subcommittee to bridge the gender gap in surgery
- Focus: to address interests, concerns and common experiences, both professionally and personally, that face women entering the field of surgery
- Hosted Dr. Andrew Wong, an orthopedic surgeon to speak about minorities in the field of surgery
- Hosted Dr. Cianna Pender, a general surgeon and FSU College of Medicine alumni
- Hosted representatives from the Women in Surgery Career Symposium planning committee to speak to medical students about the upcoming WIS conference
- Established mentor program between medical students and local surgeons in the community
- Organized a group of 30 medical students to attend the annual Women in Surgery Conference

Research Interest Club FSU College of Medicine August 2016-December 2017

Historian

- Worked to increase the interest and awareness of research to medical students

- Hosted panel with M2 medical students who had conducted summer research in various fields to speak to incoming M1 medical students
- Organized journal clubs, guest speakers, and research outreach events

HEAL Editorial Board FSU College of Medicine — September 2016- August 2017

- Humanism Evolving through Arts and Literature journal created by FSU medical students to promote using a creative outlet to maintain health
- Responsible for editing and selecting submissions for publication

Dr. Adam Johnson, Florida State University Tallahassee, FL — January 2014- May 2014

Psychology Teaching Assistant, Interpersonal Relationships Course

- Explored interests in psychological tendencies and social interactions
- Assembled lecture presentations and aided with restructuring course material

Professional Affiliations

- Society for Neuro-Oncology (SNO) — 2019-Present
- American Physician Scientist Association (APSA) — 2019-Present
- Florida Medical Association (FMA) — 2019-Present
- American College of Surgeons (ACS) — 2019-Present
- Society for Neuroscience (SfN) — 2018-Present
- American Medical Association (AMA) — 2016-Present
- American Medical Women's Association (AMWA) — 2016-Present
- Phi Gamma Mu, Social Sciences Honor Society, Florida State University — 2013-2015
- Psi Chi, Psychology Honor Society, Florida State University — 2013-2015

Conferences & Professional Events

- **Annual Meeting of the AMA House of Delegates** Chicago, IL — June 2019
- **AMA MSS Annual Meeting** Chicago, IL — June 2019
- **FMA MSS Health Policy Lobbying Day at the Capitol** Tallahassee, FL — March 2019
- **AMA Medical Student Advocacy & Region Conference (MARC)** Washington, D.C. — March 2019
- **FSU College of Medicine Research Fair** Tallahassee, FL — February 2019
- **American College of Surgeons (ACS) Advocacy Day at the Capitol** Tallahassee, FL — January 2019
- **Society for Neuroscience (SfN) Annual Meeting** San Diego, CA — November 2018
- **American Medical Women's Association (AMWA) Annual Region 4 Conference** Tallahassee, FL — October 2018
- **National M.D./Ph.D. Student Conference** Keystone, Colorado — July 2018
- **FSU College of Medicine Life Sciences Symposium** Tallahassee, FL — February 2018
- **FSU College of Medicine Summer Research Fellow's Grand Rounds** Tallahassee, FL — October 2017
- **FSU College of Medicine Summer Research Fellow's Poster Session** Tallahassee, FL — October 2017
- **9th Annual International Women in Surgery (WIS) Career Symposium** Orlando, FL — April 2017
- **FMA Medical Student Section (MSS) Health Policy Lobbying Day at the Capitol** Tallahassee, FL — March 2017
- **American Medical Women's Association (AMWA) Annual Region 4 Conference** Tallahassee, FL — October 2016
- **Interim Meeting of the American Medical Association (AMA) House of Delegates** Orlando, FL — November 2016

Honors & Awards

- **Bryan Robinson Endowment for Neuroscience Research** Tallahassee Memorial Hospital (TMH) June 2019
- **FSU COM Summer Research Fellowship** Recipient May 2017
- **FSU Academic Dean's List** August 2013- May 2015
- **Bright Futures Academic Scholars Award** 100% 2010-2014

Certifications & Licenses

- **United State Medical Licensing Exam (USMLE) Step 1,** Pass April 2018
- **CPR Certification in Basic Life Safety (BLS)** American Heart Association 2012, 2017
- **Emergency Medical Responder (EMR)** January 2013

Manuscripts

1. **Pavlock, S.M.,** Kesarwani, A., McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). Effects of cyclophosphamide and naproxen, on behavior and neuroinflammation in a pre- and post- menopausal female mouse model. *Publication [In Preparation].*
2. Wright, K.N., Dossat, A.M., Strong, C.E., Sailer, L.L., **Pavlock, S.M.,** Kabbaj, M. (2018). Optogenetic inhibition of medial prefrontal cortex projections to the nucleus accumbens core and methyl supplementation via L-Methionine attenuates cocaine-primed reinstatement. *Integrative Zoology. doi:10.1111/1749-4877.12365. Publication.*

Abstracts

1. **Pavlock, S.M.,** Kesarwani, A., McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). The effects of a non-steroidal anti-inflammatory agent on cyclophosphamide induced changes in behavior, hippocampal neurogenesis and neuroinflammation in a mouse model. Society for Neuroscience (Sfn) Annual Meeting. Chicago, IL. *Abstract (Accepted).*
2. Kesarwani, A., **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). Coadministration of naproxen and cyclophosphamide on behavior and neuroinflammation in a mouse model. Annual Scientific Meeting of the American College of Physicians (ACP)- Florida Chapter. Fort Lauderdale, FL. *Abstract (Competitively Selected).*
3. **Pavlock, S.M.**, Kesarwani, A., McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). The effects of cyclophosphamide and naproxen on neuroinflammation in a mouse model. Florida Medical Association (FMA) David A. Paulus, M.D. Poster Symposium at the FMA Annual Meeting. Orlando, FL. *Abstract (Competitively Selected).*
4. Jean-Pierre, P., **Pavlock, S.M.**, Kesarwani, A., McCarthy, D.M., Bhide, P.G. (2019). Chemotherapy, inflammation, hippocampal volume, and neurobehavioral functioning in C57BL/6 mice treated with nonsteroidal anti-inflammatory drug. American Society of Clinical Oncology (ASCO) Annual Meeting. Chicago, IL. *Abstract (Competitively Selected).*
5. Kesarwani, A., **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). The effects of non-steroidal anti-inflammatory agents on cyclophosphamide induced behavioral changes in a mouse model. Student National Medical Association (SNMA) Annual Meeting. Philadelphia, PA. *Abstract (Competitively Selected).*
6. **Pavlock, S.M.,** McCarthy, D.M., Martin, M.M., Jean-Pierre, P., Bhide, P.G. (2018). The effects of chemotherapy on cognitive behavior and neurogenesis in an animal model of pre- and post- menopausal females. National M.D. /Ph.D. Student Conference. Keystone, CO. *Abstract.*

Oral Presentations

1. **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2017). The effects of chemotherapy on cognitive behavior and neurogenesis in an animal model of pre- and post- menopausal females. Florida State University College of Medicine, Summer Research Fellows Grand Rounds. Tallahassee, FL. *Oral Presentation.*

Poster Presentations

1. **Pavlock, S.M**., Kesarwani, A., McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). The effects of cyclophosphamide and naproxen on neuroinflammation in a mouse model. Florida Medical Association (FMA) David A. Paulus, M.D. Poster Symposium at the FMA Annual Meeting. Orlando, FL. *Poster.*
2. Kesarwani, A., **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). The effects of non-steroidal anti-inflammatory agents on cyclophosphamide induced behavioral changes in a mouse model. Student National Medical Association (SNMA) Annual Meeting. Philadelphia, PA. *Poster.*
3. **Pavlock, S.M.,** Kesarwani, A., McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). Dose-dependent effects of cyclophosphamide, a breast cancer chemotherapy agent on behavioral and neuroanatomical changes in a mouse model. Florida State University College of Medicine, Research Fair. Tallahassee, FL. *Poster.*
4. Kesarwani, A., **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2019). Effects of anti-inflammatory treatment on chemotherapy-induced neuroinflammation and behavioral changes. Florida State University College of Medicine, Research Fair. Tallahassee, FL. *Poster.*
5. Kesarwani, A., **Pavlock, S.M.,** McCarthy, D.M., Jean-Pierre, P., Bhide, P.G. (2018). Beneficial effects of a non-steroidal anti-inflammatory drug (NSAID) on chemotherapy-induced behavior changes. Florida State University College of Medicine, Summer Research Fellows Poster Session. Tallahassee, FL. *Poster.*
6. **Pavlock, S.M.,** McCarthy, D.M., Martin, M.M., Jean-Pierre, P., Bhide, P.G. (2018). The effects of chemotherapy on cognitive behavior and neurogenesis in an animal model of pre- and post- menopausal females. National M.D. /Ph.D. Student Conference. Keystone, CO. *Poster.*
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Research Skills & Techniques

- Conceptualizing, designing and conducting experiments
- Presenting experimental findings to committees, peers, and general audiences
- Working alongside and collaborating with a team of researchers
- Critically writing and reviewing manuscripts for publication
- Statistical analysis: 2-way analysis of variance (ANOVA), 3- way ANVOA, general linear model, student's t-test
- Tissue collection: brain extractions, adult hippocampi microdissections, trunk blood collections, multi-organ dissections
- Tissue preparation: tissue sectioning with cryostat, vibratome, sliding microtome; tissue mounting
- Microscopy: confocal and light microscopy
- Histological assays: immunohistochemistry/immunofluorescence,
- Molecular assays: protein isolation and purification, western blot analysis
- Cell culture: maintaining cell colony, tumorsphere formation, cell migration assays, cell proliferation assays
- Pharmacological manipulation: subcutaneous and intraperitoneal (IP) injections
- Behavioral assays: y-maze (spatial working memory), photo beam activity system (locomotor activity), object-based attention (OBA, attention), elevated plus maze (EPM, anxiety), elevated zero maze (EZM, anxiety), tail suspension test (TST, learned helplessness), operant chamber self-administration (addiction).
- Optogenetic training: delivering viral vectors, cathode implementation, optogenetic inhibition
- Software programs: GraphPad Prism 8.0, Adobe Photoshop, Adobe InDesign, EndNote, JWatcher, Microsoft Publisher, Microsoft Excel, Microsoft PowerPoint, Pages, Keynote, Evernote.

- Organizational skills: organizing professional and leadership development events, time management, and generation of daily, weekly, and monthly schedules.
- Project management skills: management of multiple projects and coordination of people involved

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
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- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: **David** (First) **Aaron** (Middle) **Tyson** (Last)

Address: **2000 SW 16th St Apt 25** (Street address)

City, State, Zip: **Gainesville** (City) **Florida** (State) **32608** (Zip)

Telephone: **919-951-5051** (Day) **919-951-5051** (Evening)

Email address: **david.tyson@ufl.edu**

Medical School: **University of Florida College of Medicine**

Expected graduation: **May 2021**

AMA-MSS Region (1-7): **4**

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Corey Howard, MD, FACP Florida State Delegation Chair State: FL

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Patrick Duff M.D.

Signatory's name and title (Please print): Patrick Duff, M.D. Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

I am a practicing Jewish person.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☑ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☑ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☑ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☑ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

David Tyson

2000 SW 16th St Apt 25, Gainesville, Florida 32608,

david.tyson@ufl.edu, (919) 951-5051

Education

University of Florida College of Medicine, class of 2021

Masters of Science in Biomedical Science, Duke University, 2015-2016

Bachelors of Arts, History, University of Virginia, 2010-2014

Honors and Awards

FMA Organized Medicine Leadership Award – 2018
UF COM Medical Student Research Project (MSRP) – 2018
National Science Foundation, REU Award – 2014

Professional organizations and activities

AMA MSS:
- Region 4 Chair 2018-2019
- Hosted first annual Region 4 Regional Conference at UF COM January 2019
- Delegate to AMA-MSS for UF COM 2018
- Alternate Delegate to AMA-MSS for UF COM 2017

Florida Medicine Association
- Medical Student Section Chair 2019-2020
- Vice Chair of Legislation and Policy 2018-2019
- Delegate to FMA House of Delegates for UF COM 2018

Alachua County Medical Society
- Student Representative on ACMS Board 2018-2019
- Advisory Board Member to ACMS Board 2019-present

Other
- UF COM Internal Medicine Interest Group President 2018-2019

Publications

Resolutions

Regulating Front-of-Package Labels on Food Products
Lauren Benning, **David Tyson**, Steven Peretiatko, Ian Motie, Benjamin Chadek-Feeley
Adopted at AMA-MSS Annual 2018

Opposing Sexual Orientation Change Therapy
David Tyson, Medical Student Section sponsored
Adopted at FMA Annual 2019

Manuscripts

Anther smut disease caused by Microbotryum on berry campion Silene baccifera: endemic pathogen or host shift?. *Plant pathology* 67.9 (2018) **Tyson, D. A**., J. Antonovics, and E. L. Bruns.

Exercise increases and browns muscle lipid in high-fat diet-fed mice. *Frontiers in endocrinology* Morton, T.L., Galior, K., McGrath, C., Wu, X., Uzer, G., Uzer, G.B., Sen, B., Xie, Z., **Tyson, D**., Rubin, J. and Styner, M., 2016.

TASK-3 channel deletion in mice recapitulates low-renin essential hypertension. *Hypertension*
Guagliardo, N.A., Yao, J., Hu, C., Schertz, E.M., **Tyson, D.A**., Carey, R.M., Bayliss, D.A. and Barrett, P.Q., 2012.

Published Abstracts
Radiation Therapy Patient Presentation to the Emergency Department in a Medically Underserved Region, *Academic Emergency Medicine Special Edition: 2019 Annual Meeting Supplement*
David A. Tyson, Kathryn E. Hitchcock, Laura Towery, and Carolyn K. Holland

Interdisciplinary Oral Health Service Event for Underserved Areas in and Around Alachua County. 2018 American Academy of Pediatrics (AAP) National Conference & Exhibition. Madison Szar and **David Tyson**

Presentations
Radiation Therapy Patient Presentation to the Emergency Department in a Medically Underserved Region – presented at:
SAEM 2019 Annual Meeting 2019 Las Vegas, Nevada
UF COM Celebration of Research 2019 Gainesville, Florida

Recent Employment
Clinical Research Associate, QuintilesIMS (September 2016-June 2017)

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST..
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Sameen (First) Middle Ansari (Last)

Address: 170 Brookline Ave., Unit 811 (Street address)

City, State, Zip: Boston (City) MA (State) 02155 (Zip)

Telephone: 909-979-7436 (Day) Evening

Email address: sansari2@oakland.edu

Medical School: Oakland University William Beaumont School of Medicine

Expected graduation: 2021

AMA-MSS Region (1-7): 5

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Julie L Novak

Signatory's name and title (Please print): Julie L. Novak, Chief Exec. Officer State: MI

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): _____

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print):_____State: _____

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Cynthia H Ledford, MD Associate Dean

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☒ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☒ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☒ No
Explain, if desired:

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Email: mss@ama-assn.org

SAMEEN ANSARI

665 Huntington Ave, Boston, MA 02115 • (909) 979-7436 • sameenansari@hsph.harvard.edu

EDUCATION

2019-Present **Harvard T.H. Chan School of Public Health**
Boston, MA
Master of Public Health (MPH) in Health Policy, anticipated May 2020

2016-Present **Oakland University William Beaumont School of Medicine (OUWB)**
Rochester, MI
Doctor of Medicine (M.D.), anticipated May 2021

2010-2013 **Loyola University Chicago**
Chicago, IL
Bachelor of Science in Biology, Magna Cum Laude

HONORS AND AWARDS

2019 **Gold Humanism Honor Society**
Oakland University William Beaumont School of Medicine, Rochester, MI
- Nominated for this national honors society by colleagues for having outstanding commitment to humanistic values, professionalism, communication, and community service
- The Gold Foundation limits the number of inductees to 10-15% of each class

2018 **Diversity and Inclusion Student Excellence Award**
Oakland University William Beaumont School of Medicine, Rochester, MI
- Awarded to students that go beyond primary responsibilities to demonstrate leadership and service related to diversity both at OUWB and the community-at-large
- Won for co-founding the Chiasm Dialogue Group due to its outstanding structure and participation of nearly 100 students across all of our dialogues from the M1/M2 classes, with over 50% participation from the M2 class

2018 **Excellence in Fundraising Award**
Michigan State Medical Society (MSMS), East Lansing, MI
- The MSMS presented OUWB's American Medical Association (AMA) chapter with this award after we raised an outstanding $1390 through the academic year, around three times greater than all other Michigan AMA chapters combined

2018 **Excellence in Advocacy Award**
Michigan State Medical Society, East Lansing, MI
- The MSMS presented OUWB's AMA chapter with this award after we held monthly advocacy calls, earning us more advocacy participation points than all other Michigan AMA chapters combined

2012-2013 **Mulcahy Scholarship**
Loyola University Chicago, Chicago, IL
- Awarded upon recommendation of a faculty member to students in the hard sciences, and includes a research budget and stipend

2012 **Provost Fellowship**
Loyola University Chicago, Chicago, IL
- Awarded upon recommendation of a faculty member to students in the hard sciences who wish to conduct summer research

LEADERSHIP EXPERIENCE

Massachusetts State House, Boston, MA

2019 **Public Health Fellow**
Senator Joanne M. Comerford - Massachusetts Legislature
- One of two students selected to serve as a legislative fellow for Senator Comerford, Chair of the Joint Committee on Public Health
- Prepare testimonies, bill summaries, and legislative agendas with a focus on public health policy
- Attend regular State Senate committees

Michigan State Medical Society (MSMS), East Lansing, MI

2018-Present **Committee on Health Care Quality, Efficiency and Economics**
Michigan State Medical Society Standing Committee
- This committee discusses the statewide promotion of quality, safety, and efficiency in healthcare. It also functions to set MSMS strategic priorities and foster collaboration between health plans, regulators and employers

2018-Present **Board of Directors (BOD)**
Medical Student Section Governing Council
- Represent interests of over 1000 medical student AMA members from all seven MI medical schools on the MSMS Board of Directors, consisting of 30 physician members
- Creating novel recruitment programs for physicians, residents and medical students across Michigan
- Served on the BOD's Healthcare Delivery & Education Committee and currently serving on the Legislative Policy Committee

2017-2018 **Director of Community Service**
Medical Student Section (MSS) Governing Council
- Coordinated a statewide community service initiative with seven medical schools on the theme of "Nutrition in the Setting of Food Insecurity"
- Worked with FoodCorps to organize Michigan student fundraising efforts totaling $2,200
- Collaborated with the Oakland County Medical Society to organize a CME networking event for 80 physicians and medical students across Michigan
- Designed and introduced three Michigan State Medical Society awards to be given to outstanding AMA chapters across Michigan. Organized awards ceremony presentation by MSMS President Dr. Cheryl Gibson-Fountain
- Helped initiate monthly statewide advocacy calls day
- Interviewed physicians and contributed to the production of a promotional video for the MSMS-MSS

Oakland University William Beaumont School of Medicine (OUWB), Rochester, MI

2018-2019 **M3 Class Senator**
Medical Student Government
- Represented and advocate for the concerns of 117 students during clerkships
- Lead student efforts to restructure M1/M2 clinical skills classes to better prepare students for clerkship years

2016-2019 **Class Representative for the M1/M2 Curriculum Subcommittee**
Medical Student Government
- Provided feedback from the M1 and M2 classes to over 20 Course and Clerkship Directors regarding student concerns over curriculum changes
- Upon my suggestion, faculty added a "general curricular concerns" section in all M1-M2 mandatory course evaluations

2017-2018 **National Delegate**
American Medical Association Medical Student Section (AMA-MSS) at OUWB
- Attended Oakland County Medical Society (OCMS) Board of Directors Meetings and other OCMS Committee meetings and provided student feedback
- Attended monthly Michigan State Medical Society (MSMS) Medical Student Section conference calls and national AMA and state MSMS conferences as the OUWB Delegate
- Helped organize Resolution Writing Workshop, advocacy efforts, recruitment events, and fundraising efforts for FoodCorps totaling $1390

2017-2018 **Co-founder**
Chiasm Dialogue Group
- Facilitating dialogues within OUWB to foster an environment in which peers can constructively acknowledge and discuss diverse viewpoints
- Working with Diversity and Inclusion to establish a permanent "student dialogue" facilitator program at OUWB
- Won the 2018 OUWB Diversity and Inclusion Award

Loyola University Chicago, Chicago, IL

2011 –2013 **Senior Writing Tutor**
Loyola University Chicago Writing Center
- Tutored more than 65 undergraduate and graduate students in science, humanities and business courses

2010 –2013 **Group Leader/Speaker**
Muslim Student Association (MSA)
- Facilitated team-building activities for my small group at the annual three-day MSA retreat, spoke at 13 events in front of groups as large as 45 people about personal development, and engaged in interfaith groups

RESEARCH EXPERIENCE

2016–Present **Co-Investigator**
Oakland University William Beaumont School of Medicine, Rochester, MI
Health Information Outreach to Homeless Patients at the HOPE Recuperative Care Center
Project Mentors: Misa Mi, PhD, MLIS, AHIP and Jason Wasserman, PhD
- Provided 1-1.5 hour health literacy training sessions teaching staff and guests how to reliably identify and search for health information
- Trained over 30 staff and homeless guests, showing a significant increase in health literacy scores for both patient and staff
- Helped create training materials such as surveys, online modules and the Health Information Resources website

2015–2016 **Research Assistant**
University of Chicago, Chicago, IL
Hospitalist Project
Project Mentor: David Meltzer, MD, PhD, Chief, Section of Hospital Medicine
- Interviewed patients regarding their hospital stays in order to gather data that could be used to improve the quality of care patients receive while hospitalized

2015–2016 **Research Assistant**
University of Chicago, Chicago, IL
Comprehensive Care Project
Project Mentor: David Meltzer, MD, PhD, Chief, Section of Hospital Medicine
- Assessed a new model of care in which the same physician cares for the patient both in the clinic and in the hospital, by contacting over 300 patients in the intensive care unit and over the phone

2012–2013 **Research Assistant**
Loyola University Chicago, Chicago, IL
Resolution and Rapid Racemization of Beckmann-derived CTV-Lactam Supramolecular Scaffold
Project Mentor: Daniel Becker, PhD
- Synthesized cyclotriveratrylene (CTV), a supramolecular scaffold with potential uses as a synthetic receptor, and compounds for DapE inhibition, which can prevent antibiotic resistance

VOLUNTEER EXPERIENCE

2018 **Tutor, Score for Success**
Grissom Middle School, Sterling Heights, MI
- Tutor middle school refugee students to increase their academic English proficiency and increase their health literacy, after which we engage them in sports

2017-Present **Member, #HappyPeriod Oakland County**
Oakland County, MI
- Reach out to local organizations such as Beaumont Hospital and Oakland University to coordinate donations and events for our newly established chapter of #HappyPeriod, which will collect feminine products and distribute them to the homeless population in the community

2016-2018 **Tutor/Mentor, Cranbrook Horizons Upward Bound**
Cranbrook Schools, Bloomfield Hills, MI
- Teach interactive classes about various wellness topics to high-achieving high school students with limited opportunities from the Detroit Metropolitan area

2012–2014 **Behavioral Health Department Volunteer**
Advocate Good Samaritan Hospital, Downers Grove, IL
- Trained new volunteers for the Behavioral Health and assisted over 250 patients by comforting them and feeding them as needed

ORAL & POSTER PRESENTATIONS

2018 **Ansari, S**., Hashmi, N., *Peer-Facilitated Dialogue as an Essential Tool in Developing Cultural Humility.* Poster Presentation at the Conference on Medicine and Religion. Saint Louis, MO. April 13, 2018.

2018 **Ansari, S**., Mi, M., Wasserman, J., *Effectiveness of Health Information Literacy Training for Patients Experiencing Homelessness.*
Oral Presentation at the American Association of Medical Colleges (AAMC), Central Group on Educational Affairs Regional Spring Meeting. Mayo Clinic College of Medicine and Science. Rochester, MN. March 21-23, 2018.
Oral Presentation at the Oakland University Graduate Student Research Conference. Oakland University William Beaumont School of Medicine. Rochester Hills, MI. March 9, 2018.

2013 **Ansari, S**., Becker, D., Sarsah, S., *Resolution and Rapid Racemization of Beckmann-derived CTV-Lactam Supramolecular Scaffold.* Poster Presentation at the Undergraduate Research and Engagement Symposium. Loyola University Chicago. Chicago, IL. April 20, 2013.

PEER-REVIEWED PUBLICATIONS

2018 Hashmi N, **Ansari S**, Fedorowicz M, Ebrecht B, Aljamal S. Resolution 38-18. *Peer-Facilitated Dialogue: An Essential Tool in Developing Cultural Humility in Medical Education*. Michigan State Medical Society House of Delegates Conference. 2018 April.

2017 Bravata G, D'Mello R, Ferman D, Anderson P, Vaidya P, Powell D, Montgomery J, Nguyen K, Pascoe A, Mitchell K, Yeisley N, **Ansari S.** Resolution 295.193MSS. *Implicit Bias: Its Effects on Health Care and Its Incorporation into Undergraduate Medical Education.* American Medical Association Medical Student Section Interim Conference. 2017 November.

WORK EXPERIENCE

2015–2016 **Emergency Department Scribe, ScribeAmerica**
Adventist Hospitals, Hinsdale, Bolingbrook, and LaGrange, IL
- Performed detailed medical charting for over 600 patients

PROFESSIONAL MEMBERSHIPS

2018-Present American Academy of Family Physicians (AAFP)
2017-Present American Association of Public Health Physicians (AAPHP)
2016-Present American Medical Association (AMA)
2016-Present Michigan State Medical Society (MSMS)
2016-Present Oakland County Medical Society (OCMS)

MEDICAL CERTIFICATIONS

2018 - 6/2020 ACLS
2018 - 6/2020 BLS

LANGUAGES

- English, Native
- Urdu/Hindi, Advanced

SAMEEN ANSARI

665 Huntington Ave, Boston, MA 02115 • (909) 979-7436 • sameenansari@hsph.harvard.edu

"Are you going to go bomb something, you terrorist"... I could not believe what I heard– how could anyone harbor prejudice towards me based on my appearance? Being from a minority racial and religious background may be why others think I am "diverse", but this only touches upon the surface of my diversity. My diversity lies in how I have cultivated a unique methodology of understanding myself as well as others, reaching out to others as a result of the discomfort I experienced.

My discomfort has been a source of self analysis, wanting to understand both the American culture I grew up in, as well as my family's Pakistani background. This has enhanced my sensitivity to others and allows me appreciate their views. I plan to use my ability to connect with others to help patients and students alike in discussing their needs with me.

My diversity fuels my determination to express the positive contributions of my identity through action. I aim to be a welcoming presence as a region five delegate, so that we can work together towards constructive outcomes.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

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Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Megan	Zaiyi	Chiu
	First	Middle	Last
Address:	860 S Basswood Drive Apt D		
	Street address		
City, State, Zip:	Bloomington	IN	47403
	City	State	Zip
Telephone:	765-409-7002		
	Day	Evening	
Email address:	mzchiu@iu.edu		
Medical School:	Indiana University School of Medicine - Bloomington		
Expected graduation:	2021		
AMA-MSS Region (1-7):	5		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Raveen Sugantharaj State: IN

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Sarah Tieman, MD

Signatory's name and title (Please print): Sarah Tieman, MD Asst. Director of Clinical Ed

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☑ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☑ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☑ Bisexual
- ☐ Gay or lesbian
- ☐ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>

☐ Yes ☑ No

Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

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Email: mss@ama-assn.org

MEGAN Z. CHIU

765-409-7002 | MZCHIU@IU.EDU



EDUCATION

INDIANA UNIVERSITY SCHOOL OF MEDICINE | BLOOMINGTON, IN

DOCTOR OF MEDICINE, ANTICIPATED MAY 2021

Student Leadership Award 2019
Global Medical Education Experience with Work The World, Pokhara, Nepal, July 2018

PURDUE UNIVERSITY | WEST LAFAYETTE, IN

BACHELOR'S OF SCIENCE IN MECHANICAL ENGINEERING WITH HONORS, RECEIVED MAY 2017

Honors College, Honors Engineering Learning Community
Purdue Presidential Scholar 2013-17
John M. Bruce Memorial Scholar 2014-15, 2015-16
Waterman Scholar 2015-16
Dean's List & Semester Honors 2013-2017
Pi Kappa Delta National Debate Competition Semi-Finalist 2014

LEADERSHIP & VOLUNTEER EXPERIENCE

BLOOMINGTON STUDENT OUTREACH COMMITTEE | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Founder & Committee Member , September 2019 - current

- Created outreach committee to increase medical student involvement with the community
- Organize preventative health screening fair with community partner, Shalom Community Center, to serve the needs of their client population, providing services including basic lab screenings, flu shots, and patient education for follow up.

INDIANA STATE MEDICAL ASSOCIATION | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Head of Public Relations and Communications, May 2019 - current

- Serve as the student editor for the ISMA Student Newsletter and maintain correspondence with ISMA staff
- Oversee all social media accounts for ISMA-MSS

Student Newsletter Editor, November 2018 – May 2019

- Created a monthly student newsletter published through the Indiana State Medical Association
- Lead content creation and organization for the student newsletter
- Coordinate student writers and maintain correspondence with Indiana State Medical Association staff

MEDICAL STUDENT COUNCIL | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Executive Committee Secretary, Spring 2019 - current

- Record the live minutes of the MSC meetings and publicize the agenda for each upcoming council meeting
- Maintain an updated MSC roster consisting of the names and email addresses of council members, committee representatives and representatives of all recognized medical student organizations
- Supervise the maintenance and updating of MSC electronic materials. This shall include, but is not limited to, uploading monthly meeting minutes, updating annual membership and contact information, updating student organization lists and contact information, and the MSC blog/newsletter
- Aid the other MSC executives in MSC business, including organizing MSC General Body Meetings and MSC Deans' Meetings

Bloomington House Representative, September 2017 – 2019

- Served as a student liaison between the Medical Student Council and the Bloomington campus class
- Conducted elections for first year officer positions and organized service activities for Bloomington students
- Served as the MUMPs (Medical Undergraduate Mentorship Partnerships) representative for Indiana University and host events every semester for undergraduates interested in attending medical school
- Served as student representative on the Student Activities Fund Committee to discuss funding requests from students or faculty

ACADEMIC STANDARDS COMMITTEE | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Student Representative, May 2018 - current

- Serve as a student liaison for the Academic Standards Committee that implements a systematic evaluation process for the curricular components (courses and clerkships) of medical education. Ensures adherence to the IU School of Medicine Institutional Learning Objectives and curricular policy; comparability of instruction, assessment and outcomes; and equivalency in grading. Reports to the Curriculum Council Steering Committee (CCSC).

INDIANAPOLIS LEARNING TECHNOLOGY COMMITTEE | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Student Representative, September 2019 - current

- Serve as a student liaison for the Indianapolis Learning Technology Committee that is responsible for allocating funds to enhance technology for the Indianapolis campus, especially with student educational resources and student technology spaces.

HOSPITAL-BASED STUDENT INTEREST GROUP CLUSTER | INDIANA UNIVERSITY SCHOOL OF MEDICINE

Regional Co-Chair, Spring 2019 - current

- Serve as a regional campus representative in the statewide Student Interest Group (SIG) Cluster, which includes the following SIGs: Anesthesiology, Emergency Medicine, Physical Medicine and Rehabilitation, Pathology, Radiology (DR and IR).
- Work with Co-chairs to organize SIG Cluster statewide events.

ALUMNI CHAPTER ADVISORY COMMITTEE | TIMMY GLOBAL HEALTH

Alumni Engagement and Networking Core Committee Chair, June 2017 – current

- Serve and lead a core committee within the Alumni Chapter Advisor Committee focusing on:
    - Medical Professional Recruitment: Identifying current and future medical professionals that can possibly serve on future, understanding the needs of medical professionals and obtain feedback, and integrating medical professionals with university chapters
    - Professional Development: connecting young alumni with older alumni chapter members, creating leadership opportunities within the alumni chapter, and gauging interest in leadership
    - Conferences: planning an alumni chapter conference to be held annually or biannually, informing alumni chapter members about Timmy Annual Conference and/or student conferences
    - Alumni Chapter Recruitment: mapping locations and career paths of current alumni chapter members, and utilizing university chapter networks to trace alumni chapter members

BOILER GOLD RUSH LEADERS ALUMNI NETWORK COMMITTEE| PURDUE UNIVERSITY

Steering Committee Member, June 2017 - current

- Serve as a member of the steering committee to help achieve the mission of the Boiler Gold Rush Leaders Alumni Network mission: to connect former Boiler Gold Rush leaders throughout the world through a social and professional network. We work to enrich the current BGR student leader's experience through fundraising, professional mentoring, and volunteerism. Our ultimate goal is to foster and maintain the connection between Purdue University, Boiler Gold Rush, and alumni leaders.

DOCTOR CAMP/CAMP MD| INDIANA UNIVERSITY SCHOOL OF MEDICINE

Camp Counselor, June 2018

- Served as the leader for camp activities for Indianapolis Doctor Camp, which is a one day summer program that encourages interest in science and medicine through fun, interactive learning. The program is designed for inner city and minority students, but is open to all students' grades 5-8.

BOILER GOLD RUSH | PURDUE UNIVERSITY

Student Orientation Committee, Fall 2015 – Fall 2016

- Served as part of a team of eight students that planned and organized Purdue's new student orientation program, welcoming over 6,000 new students over a 9-day orientation program
- Recruited and interviewed 200+ candidates for team supervisors and 1200+ candidates for team leaders
- Trained a staff consisting of 97 supervisors (54 hours of trainings) and 500+ team leaders (20 hours of trainings)
- Organized community service for staff and awareness campaign, "We Are More" to promote diversity and inclusion on campus
- Created and presented a skit for all 6,000+ new students on challenges faced during their transition into college life
- Created and implemented emotional intelligence and vulnerability in leadership trainings for 97 team supervisors
- Assisted with logistics during the week of orientation

Team Supervisor, Team Supervisor International, Fall 2014 – Summer 2015

- Mentored 10 team leader for Boiler Gold Rush and Boiler Gold Rush International, who mentored 150 new students
- Organized Boiler Gold Rush "We Are Purdue" event where diverse cultures were showcased in song and dance with over 800 students in attendance
- Served as a presenter for Culture Shock session for new international students

Team Leader, Team Leader International, Spring 2014 – Summer 2014

- Served as a mentor for new students attending Boiler Gold Rush, the orientation program, and Boiler Gold Rush International program, the international student orientation program
- Lead new students through Boiler Gold Rush and Boiler Gold Rush international programming

TIMMY GLOBAL HEALTH | PURDUE UNIVERSITY

President, Spring 2016 – Spring 2017

- Planned and organized all general, executive, and quad (Vice-President) meetings for Purdue Timmy Global Health, consisting of over 100 members
- Created directional plan for Purdue Timmy Global Health for the 2016-2017 school year
- Served as a liaison between Purdue Timmy Global Health and Student Activities and Organizations as well as all other University offices
- Communicated between Purdue Timmy Global Health and the National Timmy Global Health Headquarters
- Presented on the "Year in Review" for the Purdue chapter at the annual banquet and silent auction
- Oversaw elections for the next representation of the organization

Director of Banquet, Spring 2015 – Spring 2016

- Planned and organized annual banquet and silent auction with over 350 in attendance raising over $11,500 to continue support of Tierra Nueva and their work in Ecuador
- Applied for funding through as Student Organization Grant Allocation board
- Created all the table posters, advertisements, banquet programs, donation cards, and silent auction documents

- Assisted with advertising for the event around campus and within the Lafayette and West Lafayette community
- Coordinated a banquet committee of 8 members with tasks throughout the year
- Communicated and coordinated with corporate donors, local sponsors, and other student organizations for the event

Banquet Committee Member, Spring 2014 – Spring15

- Contacted and collected art and other donations for the silent auction
- Assisted in setting up during the day of the banquet and silent auction
- Assisted with advertising for the event around campus and within the Lafayette and West Lafayette community
- Communicated and coordinated with other student organizations to attend or sponsor the event

LUM After-School Program Volunteer, 2013-14

- Worked with grade school students in the Lafayette Urban Ministry After-School Program, supporting the existing program staff

GOAL After-School Volunteer, 2015-16

- Worked with IU Health in GOAL program (Get On-board Active Living), providing children and families the opportunity to receive education and support on healthy habits
- Presented lesson plans on nutrition, physical activity, and behavioral habits in hopes to create life-long changes for an active life style

Ecuador Medical Brigade, Spring 2016

- Served in a medical brigade in 5 different rural communities surrounding Quito, Ecuador providing quality care for 500+ patients adhering to the sustainable model of Timmy Global Health; Worked alongside Timmy's local partner, Fundación Tierra Nueva
- Fundraised for medical supplies for the trip, patient transportation costs for referral care, and other medical expenses

MORTAR BOARD, PURDUE UNIVERSITY

Tapping Co-Chair, Fall 2016 – Spring 2017

- Coordinated logistics for 40 existing members to "tap"/notify new members of Mortar Board, a national honor society for college seniors, who are selected by the previous class and nominated anonymously by University staff or other student leaders
- Created grids for members to work in teams to tap new members over 12 hours
- Created all the media used in tapping day and all welcoming events
- Paired senior and junior members in mentoring pairs
- Planned welcoming events for new members to learn about the society as well as get to know past and present members

OLD MASTERS, PURDUE UNIVERSITY

Old Master Host, Fall 2016 – Spring 2017

- Acted as student liaison between returning, distinguished Purdue Alumni and Purdue University
- Assisted in networking students with Purdue Alumni and promoted marketing for the Old Masters Program

RAISING AWARENESS IN INTERNATIONAL MEDICINE, PURDUE UNIVERSITY

Director of Missions, Spring 2014 - Spring 2015

- Coordinated Guatemala and Nicaragua Service Trip
- Served as Guatemala Service Trip Leader
- Planned pre-trip meetings to prepare trip goers for both trips

Guatemala Service Trip Volunteer & Trip Leader (192 hours), March 2015

- Coordinated service trip with trip goers and IVHQ
- Worked with Student Activities and Organizations to ensure trip went smoothly
- Planned pre-trip meetings to prepare trip goers
- Assisted International Volunteer HQ in serving local clinics around Antigua, Guatemala

Nicaragua Service Trip Volunteer (168 hours), January 2014

- Assisted local non-profit, Amigos for Christ, in building clean water systems in rural communities in Nicaragua
- Fundraised for Amigos for Christ in their efforts to provide communities with clean water systems, more sanitary plumbing, proper kitchen ventilation systems, and other basic needs

RESEARCH EXPERIENCE

SUMMER UNDERGRADUATE RESEARCH FELLOWSHIP | YALE SCHOOL OF MEDICINE

KUH/NIH/NIDDK Research in PTK6 Expression in Kidneys, Dr. Alda Tufro, Summer 2016

- Worked on studying a case of atypical Hemolytic Uremic Syndrome linked to a nonsense mutation in the PTK6 gene, not studied in the kidneys before; CRISPR-Cas9 system was used to induce the human mutation in HEK cells for further study; experimentation was conducted to further understand its importance in kidney function
- Learned cell culture and immunohistochemistry techniques
- Presented research at Mayo Clinic with other NIH programs around the country

SUMMER UNDERGRADUATE RESEARCH FELLOWSHIP | PURDUE UNIVERSITY

Mobile Molecular Diagnostics in Global Health, Dr. Jacqueline Linnes, Summer 2015

- Worked on combining different aspects of recent developments in the field of paper-based POC diagnostics to develop and optimize an in-house built cell-phone powered LED-based lateral flow diagnostic device for low-resource locations.

STUDENT RESEARCHER | PURDUE UNIVERSITY

Fall 2014 – Spring 2015, Mechanisms of Traumatic Brain Injury, Dr. Riyi Shi

- Conducted trials and collected data to see correlation between traumatic brain injury and the specific impacts on brain and behavioral performance.

Spring 2014, Cancer Screening Software, Dr. Eric Nauman

- Developed and adjusted existing MATLAB model to create contours around brain tumors in MRI images and to identify permeability of the tumor tissue to help improve methodology for treatment.

CONFERENCES ATTENDED

MONROE COUNTY 3RD ANNUAL OPIOID SUMMIT | BLOOMINGTON, INDIANA
Participant, Sept 24th, 2019

INDIANA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION | NOBLESVILLE, INDIANA
Medical Student Section Alternate Delegate, Sept 13th – Sept 15th, 2019

AMERICAN MEDICAL ASSOCIATION ANNUAL MEETING | CHICAGO, ILLIONOIS
Medical Student Section Indiana University School of Medicine – Bloomington Alternate Delegate, Region 5 Governing Council Secretary, June 6th – 8th, 2019

AMERICAN MEDICAL ASSOCIATION INTERIM MEETING | NATIONAL HARBOR, MARYLAND
Medical Student Section Indiana University School of Medicine – Bloomington Alternate Delegate, Nov 8th – 10th, 2018

INDIANA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION | NOBLESVILLE, INDIANA
Medical Student Section Alternate Delegate, Sept 14th – Sept 16th, 2018

AMERICAN MEDICAL ASSOCIATION ANNUAL MEETING | CHICAGO, ILLIONOIS
Medical Student Section Indiana University School of Medicine – Bloomington Alternate Delegate, June 7th –9th, 2018

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT ADVOCACY AND REGION CONFERENCE | WASHINGTON D.C.
Medical Student Section Indiana University School of Medicine – Bloomington Representative, March 9th –10th, 2018

PRESENTATIONS AND PUBLICATIONS

AMERICAN WOMEN'S MEDICAL ASSOCIATION CONVENTION POSTER PRESENTATION | NEW YORK CITY, NEW YORK

…But What About You? Caregiving While Managing Chronic Illnesses with Jenny Baenziger, MD, IUSM – Eskenzai Health, Debbie Pavey, IUSM, and Aubrey Kenefick, IUSM

- **Abstract:** A caregiver is someone who assumes the responsibility of the physical and emotional wellbeing of another person who is unable to care for themself due to illness, disability, or incapacity. In the United States, approximately 75% of adult caregivers are female. These women universally report and suffer higher instances of depression, anxiety, stress, chronic illness, difficulty sleeping, and other detrimental conditions. Research has shown that female caregivers often prioritize their vital roles as carers at the expense of suppressing, denying, and ignoring their own illnesses. Little research has been done regarding the effective co-management of chronic disease and the psychosocial, financial, and physical burdens of caregiving itself. This phenomenon of double-burden chronic illness caregiving constitutes a significant issue in women's health, and describes a population at risk and in need of clinical surveillance. The psychological stress of caregiving combined with the stress of caring for one's own illnesses exacerbates the health of caregivers. While physicians may be aware of this relationship, they often do not identify it in their patients. Here, we suggest the implementation of a three-question screening tool to identify caregivers, their own illnesses, and whether they suffer from burnout. We hope such a tool will benefit both the caregiver and her dependent(s).
- **Case Summary**: A 67 year old female African American with generalized anxiety, depression, diabetes mellitus (T2), hepatitis C, chronic back pain, and panic attacks describes heightened anxiety after her disabled grandson with cerebral palsy and severely limited quotidian function aged out of school. Recently, an ankle injury has limited her mobility, affecting both her own health and that of her dependent. In a phone interview, the patient detailed her difficulties in finding a reliable physician of her own, maintaining her own health, and caring for her grandson by herself.

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES, DIVISION OF KIDNEY, UROLOGIC, AND HEMATOLOGIC DISEASES, SUMMER UNDERGRADUATE RESEARCH CONFERENCE | MAYO CLINIC, ROCHESTER, MN

KUH/NIH/NIDDK Research in PTK6 Expression in Kidneys with Dr. Alda Tufro, Aug 4th – 6th, 2016

- Presented a case of atypical Hemolytic Uremic Syndrome linked to a nonsense mutation in the PTK6 gene, not studied in the kidneys before; CRISPR-Cas9 system was used to induce the human mutation in HEK cells for further study; experimentation was conducted to further understand its importance in kidney function

PATENT: TEMPERATURE CONTROLLED VALVES FOR PAPER-BASED MICROFLUIDIC SYSTEMS

Publication number: 20190126270, Publication date: May 2, 2019, Applicant: Purdue Research Foundation, Inventors: Jacqueline C Linnes, Megan Zaiyi Chiu, Rui J Shen

- **Abstract:** The present invention relates to a low-cost, thermally reversible valve for paper-fluidic diagnostic devices. In particular, this invention demonstrates a tunable valve mechanism fabricated by wax-ink printing and localized heating via thin-film resistors to sequentially release liquids through a cellulose or nitrocellulose membrane. The wax-ink valve can obstruct fluid flow for a sustained time and are thermally actuated to release a controlled amount of liquid past the valve. This integrated paper-fluidic diagnostic assay device requires minimal user involvement, can be easily manufactured and tuned to meet various fluid delivery timing and incubation needs.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Haidn (First) Ellis (Middle) Foster (Last)

Address: 810 Greer St (Street address)

City, State, Zip: Covington (City) KY (State) 41011 (Zip)

Telephone: 206.228.2676 (Day) _____ (Evening)

Email address: fosterhe@mail.uc.edu

Medical School: University of Cincinnati College of Medicine

Expected graduation: 2021

AMA-MSS Region (1-7): 5

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**
2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Todd Baker, CEO State: OH

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Aurora Bennett, M.D.

Signatory's name and title (Please print): Dr. Aurora Bennett

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

   See attached.

8. **Demographics.** The following questions are optional:

   Are you Hispanic? ☐ Yes ☐ No

   What is your self-identified race?
   - ☐ White
   - ☐ Black
   - ☐ Asian
   - ☐ American Indian/Alaska Native
   - ☐ Pacific Islander
   - ☐ Other:
   - ☐ Prefer not to respond

   What is your gender identity?
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Other:
   - ☐ Prefer not to respond

   What is your sexual orientation?
   - ☐ Bisexual
   - ☐ Gay or lesbian
   - ☐ Heterosexual/Straight
   - ☐ Other:
   - ☐ Prefer not to respond

   Would you describe yourself as having a disability/being differently-abled?
   ☐ Yes ☐ No
   Explain, if desired:

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Email: mss@ama-assn.org

****Optional Release to External Organization Positions –** For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☑ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☐ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 11, 2019 AT 11:59PM/CST.

Email: mss@ama-assn.org

Curriculum Vitae

HAIDN ELLIS FOSTER

CONTACT INFORMATION

Address: 810 Greer St.
Covington, KY 41011

Phone: (206) 228-2676
Email: haidn@haidnfoster.com
Web: www.haidnfoster.com

EDUCATION

M.D., University of Cincinnati College of Medicine (Cincinnati, OH) — Exp. 05/2021

B.S., Science, Portland State University (Portland, OR) — 06/2015

M.A., English, University of Washington (Seattle, WA) — 12/2009
Thesis advisor: Joseph Butwin, Ph.D.

B.A., English, University of Washington (Seattle, WA) — 06/2008
Cum Laude, Distinction in Creative Writing

PROFESSIONAL CERTIFICATIONS

Basic Certificate in Quality & Safety, Institute for Healthcare Improvement — 12/2018

Basic Life Support for Healthcare Professionals, American Heart Association — 2017 – Present
(Certification #: 195504795460)

OTHER PROFESSIONAL POSITIONS

Pride in Practice (Covington, KY), *President & Editor-in-Chief* — 2018 – Present

SwayHub (Seattle, WA), *Chief Executive Officer* — 2007 – 2014

Seattle Magazine (Seattle, WA), *Editorial Assistant* — 2007 – 2008

PROFESSIONAL SOCIETIES

American Medical Association

- AMA Ambassador — 2019 – Present
- House of Delegates, *Alternate Delegate* — 2018 – Present
- Medical Student Section (MSS)
  - Region 5 (OH, KY, MI, IN & WV), *Vice Chair* — 2019 – Present
  - Reference Committee, *Vice Chair* — 2019
    - *Member* — 2018, 2019
  - MSS, *Delegate* — 2018

- Committee on LGBTQ+ Issues, *Member* 2018 – Present
- University of Cincinnati COM Section, *Co-President* 2018 – 2019

Ohio State Medical Association

- House of Delegates, *Delegate* 2019
- Resolutions Committee, *Member* 2019
- Medical Student Section (MSS)
  - Resolutions Committee, *Member* 2019
  - University of Cincinnati COM Section, *Co-President* 2018 – 2019

Society for Neuro-Oncology 2017 – Present

American Society of Clinical Oncology 2017 – Present

American College of Physicians 2017 – Present

Oregon Entrepreneur's Network

- Marketing Committee, *Member* 2013 – 2014

EDITORIAL ACTIVITIES

Other Editorial Roles

Pride in Practice, *Editor-in-Chief* 2018 – Present

HONORS & PRIZES

University of Cincinnati College of Medicine

- Golden Scalpel Award for Dissection Excellence 06/2019
- LGBTQ Student Activist Award 04/2019
- Best Clinical Research Poster (1 of 4 recipients) 11/2018
- Medical Marijuana Task Force Winning Group (1 of 3 recipient groups) 11/2018
- Medical Student Scholar in Neuroscience 2017 – Present

Portland State University

- NRHH Academic Achievement Award 2015

Portland Community College

- President's List (2x) 2014

University of Washington

- Sigma Tau Delta English Honor Society 2007 – 2009
  - *Co-President* 2008 – 2009
- Certificate of High Scholarship 2007
- Dean's List (5x) 2007 – 2009

Bellevue College

- Phi Theta Kappa Honor Society 2004 – 2006

REPORT OF LOCAL TEACHING & TRAINING

Local Invited Presentations

Virtual Drugs, Real Outcomes: Reproduction of Molecular Effects via Radio-Frequency Electromagnetic Radiation | MedTechi student group, University of Cincinnati College of Medicine	02/2019
Out in Health Care (panel presentation) | Out in Health Care student group, University of Cincinnati	01/2019

REPORT OF REGIONAL, NATIONAL & INTERNATIONAL INVITED TEACHING & PRESENTATIONS

Formal Teaching of Peers (e.g., CME & other continuing education courses)

Differences in Sex Development (DSD): Clinical and Ethical Implications for Providers, Patients and Parents | American Medical Association (Planning Committee member)	06/2019

Regional Invited Presentations

Bridging the Gap: Supplementing Formal Curricula to Improve LGBTQ+ Medical Education | Transforming Care Conference, Equitas Health	Exp. 10/2019

REPORT OF EDUCATION OF PATIENTS & SERVICE TO THE COMMUNITY

Activities

University of Cincinnati College of Medicine

- Dept. of Admissions, *Multiple Mini Interview Rater* 2017 – Present
- Dept. of Admissions, *Tour Guide* 2017 – Present
- Oncology Interest Group, *Co-President* 2018 – 2019
- UCCOM Pride, *Policy Chair* 2018 – 2019

Medical Volunteers of the University of Cincinnati

- Clinical Volunteer 2017 – Present

Ronald McDonald House of Cincinnati

- Volunteer 2017 – Present

Catholic Community Services of Western Washington

- Youth Tutoring Program, *Volunteer Tutor* 2017

Oregon Health & Science University

- Healthcare Volunteer Services, *Clinical Volunteer* 2013 – 2015
- Trauma Nursing Conference Series, *Volunteer* 2013 – 2015

Recognition

Members Move Medicine profile, American Medical Association	Exp. 2019
Two Bearcats honored for LGBTQ activism: Public health alum and medical student make community impact	06/2019
"Pride in Practice offers resource for change," President Pinto's Report to the Board of Trustees	02/2019
"Inspiring Stories: Haidn Foster," American Association of Medical Colleges	02/2019
"Med student launches LGBTQ online publication," The News Record	02/2019
"UC medical student launches LGBT health care publication: 'Pride in Practice' serves as a resource for change," UC News	01/2019
"Section Spotlight: University of Cincinnati College of Medicine," AMA-MSS Membership, Engagement & Recruitment Committee	01/2019
"UC medical students attend national AMA conference," UCCOM Dean's List	12/2018
"What were The Seattle Times' top stories of 2018? Here's the list." The Seattle Times	12/2018
"Fatal brain-eating amoeba may have come from woman's neti pot," All major news outlets	12/2018
"UC chapter of the American Medical Association celebrates Advocacy Week," UC News	11/2018
"Departmental Honors Spotlight," UW Department of English	2009

REPORT OF SCHOLARSHIP

Peer-Reviewed Scholarship in Print or Other Media

Research Investigations

1. **Foster H**, Piper K, DePledge L, Li HF, Scanlan J, Yoon JG, Boeckh M, Cobbs C. Human cytomegalovirus seropositivity is associated with decreased survival in glioblastoma patients. *Neuro-Oncology Advances*. 2019;1(1). doi:10.1093/noajnl/vdz020
2. Ulasov I, **Foster H**, Butters M, Yoon JG, Ozawa T, Nicolaides T, Figueroa X, Hothi P, Prados M, Butters J, Cobbs C. Precision knockdown of EGFR gene expression using radio frequency electromagnetic energy. *Journal of Neuro-Oncology*. 2017;133(2):257-264. doi:10.1007/s11060-017-2440-x. PMID: 28434113.

Other Peer-Reviewed Scholarship

1. Foster H, Piper K, DePledge L, Cobbs C. Glioblastoma cancer stem cells: Frontiers in targeted immunotherapy. In progress.

2. Piper K, **Foster H**, Gabel B, Nabors B, Cobbs C. Glioblastoma Mimicking Viral Encephalitis Responds to Acyclovir: A Case Series and Literature Review. *Frontiers in Oncology*. 2019;9:8. doi:10.3389/fonc.2019.00008. PMID: 30723703.
3. Piper KJ, **Foster H**, Susanto D, Maree CL, Thornton SD, Cobbs CS. Fatal *Balamuthia mandrillaris* brain infection associated with improper nasal lavage. *International Journal of Infectious Diseases*. 2018;77:18-22. doi:10.1016/j.ijid.2018.09.013. PMID: 30243910.
4. **Foster H**, Ulasov I, Cobbs C. Human cytomegalovirus-mediated immunomodulation: Effects on glioblastoma progression. *Biochimica et Biophysica Acta (BBA) - Reviews on Cancer*. 2017;1868(1):273-276. doi:10.1016/j.bbcan.2017.05.006. PMID: 28554666.

Non-Peer Reviewed Scientific or Medical Scholarship/Materials in Print or Other Media

Reviews, Chapters, Monographs & Editorials

1. **Foster H**, Cobbs CS. Viruses and Glioblastoma: Affliction or Opportunity? In: Robertson ES, editor. *Microbiome and Cancer*. Current Cancer Research. Cham: Humana Press; 2019. p 67-86. doi:10.1007/978-3-030-04155-7_4.

Other Non-Peer Reviewed Publications

1. **Foster H**. Closing the LGBTQ health gap [Internet]. Medscape; 2019 Mar 29. Available from: https://www.medscape.com/viewarticle/910962.
2. **Foster H**. America's inadequate LGBTQ medical education [Internet]. KevinMD; 2019 Mar 3. Available from: https://www.kevinmd.com/blog/2019/03/americas-inadequate-lgbtq-medical-education.html

Professional Educational Materials or Reports in Print or Other Media

1. Aslam U, Dooley J, **Foster H**, Huynh P, Kumar R, Mackey T, Murphy L, Vazquez D. 2019 MSS Annual Reference Committee Report. Chicago (IL): American Medical Association; 2019. 73 p.
2. Bachelder B, Haller M, **Foster H**, Griffith D, LaPlante M, Mishr S, Sampang S, Smith C, Sternfeld W. Ohio State Medical Association 2019 House of Delegates Report of Resolutions Committee 2. Columbus (OH): Ohio State Medical Association; 2019. 16 p.
3. Benning L, Brahmaroutu A, Engel L, **Foster H**, Hubeishy M, Kinariwala K, Strohbeen S. 2018 MSS Interim Reference Committee Report. Chicago (IL): American Medical Association; 2018. 65 p.

Thesis

Foster H. Breaking down barriers: *Trilby* as an entrance point to genius through the individual and gender transgression [master's thesis]. [Seattle (WA)]: University of Washington; 2009.

Abstracts, Poster Presentations & Exhibits Presented at Professional Meetings

1. **Foster H**, Scanlan J, Piper K, Yoon JG, Cobbs C. Human cytomegalovirus seropositivity is associated with decreased survival in glioblastoma patients. Poster presented at: University of Cincinnati College of Medicine Research and Service Symposium; November 7, 2018; Cincinnati, OH.
2. Capizzano T, **Foster H**, Higgins Z, Howard P, Johns M, Kelder A, Langer M, Mendoza M, Moon J, Nickel M, O'Conor K, Perry A. Barriers to healthcare navigation: An inter-organizational analysis of key Cincinnati community stakeholders. Poster presented at: University of Cincinnati College of Medicine; April 25, 2018; Cincinnati, OH.

Health Care Policy

1. Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (H-315.967). American Medical Association. Lead author. Amendment to existing policy. Adopted A-19, House of Delegates.
2. Opposing Mandated Reporting of People Who Question Their Gender Identity (H-65.959). American Medical Association. Co-author. New HOD policy. Adopted A-19, House of Delegates.
3. Strengthening Standards for LGBTQ Medical Education. American Medical Association. Lead author. Adopted A-19. Medical Student Section.
4. Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems. American Medical Association. Co-author. Adopted A-19. Medical Student Section.
5. Affirming the Medical Spectrum of Gender (H-65.962). American Medical Association. Co-author. New HOD policy. Adopted I-18, House of Delegates.
6. Medical Spectrum of Gender (D-295.312). American Medical Association. Co-author. Amendment to existing policy. Adopted I-18, House of Delegates.

Haidn Foster

Candidate, Region 5 Delegate

Candidate Diversity Statement

Should I have the honor of being reelected to represent Region 5 as a member of the student delegation to the House of Delegates, I would use my experience and perspective as founder of an LGBTQ+ focused nonprofit and student leader in organized medicine.

I founded Pride in Practice, a 501(c)(3) public charity, in 2019 to advance the state of LGBTQ+ health care by empowering providers to give excellent care for people of all sexual orientations, gender identities, and differences in sex development. The publication has featured voices on the cutting edge of LGBTQ-inclusive care, covering topics such as developing a transgender medicine curriculum, mitigating health disparities affecting bisexual patients, building a transgender-inclusive practice, and more. I've also had the privilege of writing for publications such as Medscape and KevinMD on improving LGBTQ+ health care and medical education and was honored to receive the 2019 University of Cincinnati LGBTQ Student Activist Award.

In the AMA, I've written several successful resolutions regarding the health of sexual and gender minorities, served on the Medical Student Section (MSS) Committee on LGBTQ+ Issues, and evaluated medical student-authored resolutions as a member and vice chair of the MSS Reference Committee. I am also thrilled to help lead MSS Region 5 as vice chair and to represent the AMA as an ambassador, helping to promote the work of the American Medical Association and increase member engagement. As a member of the Ohio State Medical Association (OSMA), I've additionally served on Resolutions Committees for both the OSMA House of Delegates and the OSMA Medical Student Section, and was delegate to the OSMA House of Delegates.

I think it's important that Region 5 has diverse, qualified representation in the AMA House of Delegates, and I look forward to bringing my unique diversity of skills and experience to the position of Region 5 delegate.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Brandon (First) ZhanHon (Middle) Francis (Last)

Address: 152 East New York Street, Apt 405 (Street address)

City, State, Zip: Indianapolis (City) IN (State) 46204 (Zip)

Telephone: (812)-483-5797 (Day) (812)-483-5797 (Evening)

Email address: bzfranci@iu.edu

Medical School: Indiana University School of Medicine

Expected graduation: 2021

AMA-MSS Region (1-7): 5

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Julie D Reed

Signatory's name and title (Please print): JULIE D. REED, EVP State: IN

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: [signature] MD

Signatory's name and title (Please print): Associate Dean for Student Affairs
Emily Walwood

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Email: mss@ama-assn.org

Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. Candidate's Diversity Statement. Please describe how you will bring diversity to the position for which you are applying.

8. Demographics. The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☑ White
- ☐ Black
- ☑ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☑ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>
☐ Yes ☑ No
Explain, if desired:

Optional Release to External Organization Positions – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

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Brandon Francis

First name: Brandon
Last name: Francis
Date of birth: 03/13/1995

Address: 152 East New York Street, Apt 405, Indianapolis, IN 46204
Phone number: 8124835797
Email address: bzfranci@iu.edu

Education

08/2013 – 05/2017

Bachelor of Arts: Physics and Mathematics
Vanderbilt University, Nashville, TN

- Minor in Philosophy

08/2017 – present

Medical Degree
Indiana University School of Medicine, Evansville, IN

Leadership

08/2018 – present

House of Delegates Coordination Committee (HCC)
American Medical Association (AMA)

- Analyzed proposed Medical Student Section (MSS) and House of Delegates (HOD) resolutions and advised authors, MSS delegates, and regional delegates on conflicts, similarities, or reaffirmations of existing policy
- HCC Team Lead - oriented new members, coordinated discussions and decision-making on novelty of proposed MSS policy, and answered questions about the resolution-writing process
- Reference Committee Team Lead - provided guidance for student testimony, coordinated discussions and decision-making concerning MSS stance on HOD resolutions, and organized note-taking during HOD

05/2018 – present

Delegate
American Medical Association (AMA)

- MSS Delegate/Alternate Delegate - represented Indiana University School of Medicine - Evansville for the previous three meetings
- Region 5 Alternate Delegate - filled in for Regional Delegate at the 2019 AMA annual meeting
- Assisted in coordinating Region 5 bylaw revisions concerning election procedures and Regional Delegate responsibilities

05/2019 – present

Vice President of Administration
Indiana State Medical Association (ISMA), Indianapolis, IN

- Assisted the Chair in preparing the ISMA MSS for ISMA/AMA conventions and produced the agenda and minutes prior to meetings
- Transitioned ISMA MSS meetings to focus more on pertinent healthcare policy issues
- ISMA Delegate/Alternate Delegate - represented MSS at ISMA 2018 and 2019 annual conventions
- Reference Committee Member - served on Constitution and Bylaws Committee at ISMA 2019 annual convention

08/2017 – 04/2019

Class Representative
Indiana University School of Medicine, Evansville, IN

- Bridged communication gap between faculty, student body, and Indianapolis campus
- Assisted with the organization of various events and speakers on the Evansville campus including a homeless care package drive and a local hospice volunteer opportunity
- Redesigned orientation programming for incoming first year medical students and restructured local campus bylaws and scheduling procedures

06/2018 – present

Student Representative
Curriculum Council Steering Committee, Indianapolis, IN

- Oversaw the implementation of the Indiana University School of Medicine's newly integrated curriculum
- Gathered and analyzed reports compiled by committees tasked to analyze specific curriculum issues prior to recommending curricular changes

Work Experience

10/2015 – 05/2017

Tutor
Vanderbilt University Physics Department, Nashville, TN

- Demonstrated expertise in the field of physics
- Developed strong communication skills in order to best cater to the needs of the student
- Developed educational strategies in order to provide information in a new and exciting manner

05/2016 – 08/2017

Store Manager
Escape Evansville, Evansville, IN

- Responsible for scheduling, employee engagement, and quality customer service
- Developed and implemented new "hint" system for customer events
- Demonstrated adaptability and leadership during quick room repairs

Volunteering

01/2015 – 05/2017

Teacher
Vanderbilt Student Volunteers for Science, Nashville, TN

- Taught basic scientific concepts and experiments at a local middle school on a weekly basis
- Altered curriculum appropriately to best fit the needs of the students
- Demonstrated good teamwork skills by utilizing the strengths of all group members

08/2017 – 07/2019

Mentor
Medical Undergraduate Mentoring Partnership Organization, Evansville, IN

- Mentored for undergraduate pre-medical students
- Provided helpful information concerning the medical school application process to prepare mentees for medical school applications

08/2017 – present

Volunteer
Commodore Recruitment Program, Nashville, TN

- Interviewed prospective undergraduate students for Vanderbilt University
- Compiled and submitted concise reports of applicants' best qualifications

Research

05/2018 – 08/2018

A Comparison Between the Legacy and Newly Developed Integrated Curricula
Evansville, IN

- Investigated the impact of Indiana University School of Medicine's newly integrated curriculum on both student engagement and knowledge acquisition
- Conducted a literature review concerning the effectiveness of active learning implementation into medical school curricula
- Presented this research at the Indiana Medical Student Program for Research and Scholarship (IMPRS) 2018 Conference and the Experimental Biology 2019 Conference.
- Selected as a 2018 IMPRS Oral Presentation Finalist

Mr. Brandon Francis

American Medical Association
Medical Student Section
330 N. Wabash Avenue, Suite 39300
Chicago, IL 60611-5885

Mr. Brandon Francis
8124835797
bzfranci@iu.edu
152 East New York Street, Apt 405
Indianapolis, IN 46204

October 1, 2019
RE: Application for Region 5 Delegate

Just like every other candidate for this position, I come from a background and set of personal experiences that makes my personal perspective unique.

Being the son of an immigrant mother, I have seen the impact this has had on her and her family's healthcare experience. I vividly remember visiting my grandfather in the hospital and having my mother explain to me that she had to lie to the doctors about my grandfather's age due to fear of deportation. Growing up in a culturally Chinese household has stressed upon me the importance of hard work, dedication, and perseverance, qualities that I hope to bring to this position if selected.

Additionally, considering that the MSS is generally considered to be one of the more progressive arms of the AMA, I believe that my experience growing up in a conservative state can provide key insight and understanding into a likely underrepresented viewpoint within the MSS. My daily exposure to these conservative principles may allow me to provide insight into different arguments made against more progressive MSS goals.

Finally, my background as the former manager of Escape Evansville has provided me with a skill set unique to most medical students. For those who may not know, an escape game is when customers are "locked" in a room and tasked to complete various puzzles and riddles to escape before time expires. Being a manager at an escape game requires three very specific qualities: leadership, quick-thinking, and attention to detail. I believe that all three of these characteristics are necessary to work effectively as a regional delegate.

To me, diversity isn't just about the color of one's skin or where they come from. While this no doubt plays a heavy factor, diversity is also about the different experiences we have all had growing and learning in our own unique environments. I believe that my experience growing up in an Asian household as the child of a first generation immigrant, spending my life in a more conservative state, and as a manager at Escape Evansville has provided me with a diverse array of experiences that I look forward to bringing to this position.

Sincerely,
Brandon Francis

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name:	Alexander	Richard	Thebert
	First	Middle	Last
Address:	5630 Wolf Ridge Road		
	Street address		
City, State, Zip:	Prospect	Kentucky	40059
	City	State	Zip
Telephone:	(502) 381-4080 both		
	Day	Evening	
Email address:	arth232@uky.edu		
Medical School:	University of Kentucky College of Medicine		
Expected graduation:	2022		
AMA-MSS Region (1-7):	5		

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Patrick Hodgett, EVP State: KY

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Robert DiPaola, MD-Dean

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- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☑ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

Would you describe yourself as having a disability/being differently-abled?
☐ Yes ☑ No
Explain, if desired:

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Email: mss@ama-assn.org

Alexander Thebert
717 Old Dobbin Road,
Lexington, KY 40502
(502) 381-4080
arth232@uky.edu

EDUCATION

University of Kentucky, Doctor of Medicine, Lexington, KY — Expected 05/2022
Xavier University, Bachelor of Science, Biology, Cincinnati, OH — 05/2018

RESEARCH

Student Researcher, Department of Cellular and Molecular Physiology — 06-08/2015-2016
Advisor, Marshall Montrose, PhD, University of Cincinnati, Cincinnati, OH

- Investigated TFF2 protein in mice to understand role in epithelial regeneration.

WORK EXPERIENCE

Intern, Kentucky Regional Extension Center — 06-08/2019
UK Healthcare, Lexington, KY

- Worked on Center for Medicare and Medicaid Services grant requests for the quality payment program and analyzed KY REC client information.

LEADERSHIP AND VOLUNTEER EXPERIENCE

Programming Committee Chair, University of Kentucky AMA Chapter — 05/2019-Present
University of Kentucky College of Medicine, Lexington, KY

- Organize, schedule and hold programming events for the UK AMA Chapter, such as debates, lectures, and off-campus tours and programs.

MSOLP Coordinator, University of Kentucky AMA Chapter — 08/2018-05/2019
University of Kentucky College of Medicine, Lexington, KY and Kentucky Medical Association

- Coordinated with the KMA to set-up the Medical Student Outreach and Leadership Program.

BIBLIOGRAPHY

American Medical Association Resolutions

Shanker, A,. Shade, L., **Thebert, A.**, et al. (2019). H-295.856 Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs. *American Medical Association*, *AMA Policy Finder*. Pub Status: Published.

Geddes, J., Osterhaus, P., **Thebert, A.** (2019). 215.006MSS Amendment to H-150.949 Healthy Food Options in Hospitals. *American Medical Association – Medical Student Section Digest of Policy Actions,* Pub Status: Published.

Kentucky Medical Association Resolutions

Thebert, A., Whitehouse, K., et al. (2019). 2019-15 Regulation of the Marketing, Packaging, and Sale of Electronic Nicotine Delivery Systems in Kentucky. *Kentucky Medical Association, 2019 Resolutions Final Actions*. Pub Status: Published.

Thebert, A., MacDonald, M., Osterhaus, P. (2019). 2019-26 Support for the Establishment of a Program for Wholesale Importation of Prescription Drugs. *Kentucky Medical Association, 2019 Resolutions Final Actions*. Pub Status: Published.

Poster Presentation

Thebert, A., Aihara, E., Engevik, K., Matthis, A., Montrose, M., Role of Extracellular Calcium on Gastric Epithelial Repair of Damage. University of Cincinnati Summer Undergraduate Research Fellowship Research Symposium, 2016.

The role of AMA-MSS delegate is one bathed in politics. Delegates must not only understand the policy of the resolutions they vote on, but the politics underlying those resolutions. Because the purpose of resolutions is to guide policymakers, they are not separate from current national, state, and local politics. Delegates must also consider internal politics, as every member of the AMA brings their own unique political perspective to the table and understanding their perspective is critical to reaching them. A successful delegate can speak many political "languages", and can communicate essential information to vastly different groups in ways that they can understand. If the goal of the AMA is to get good policy passed, communication should not be the barrier keeping it from being passed. And if the groups cannot agree what "good policy" is, communication should not be keeping them from figuring out their differences and continuing from there.

Growing up in a politically diverse family, I have been surrounded by political discussions my whole life. I am lucky that while discussions flow freely, feelings stay unscathed at the end of the day. Because of this, my family has gone back to issues time and time again and I have witnessed what changes minds, what rhetoric can reach different ideologies, and what fundamental values people hold. On the flip side, I have seen what turns people away from discussions and what shuts them down. Without an understanding of where someone is coming from, it is impossible to reach them. Through my own trial and error with my family, my desire to understand how people come to positions, and my work with the KMA and AMA, I think that I possess these communication qualities. My politically diverse background has prepared me for the challenge of communicating with a diverse AMA.

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- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: *Arshjot* (First) *Singh* (Middle) *Khokhar* (Last)

Address: *202 University Manor East* (Street address)

City, State, Zip: *Hershey, PA 17033* (City / State / Zip)

Telephone: *661-993-8050* (Day / Evening)

Email address: *akhokhar@pennstatehealth.psu.edu*

Medical School: *Penn State University College of Medicine*

Expected graduation: *May 2021*

AMA-MSS Region (1-7): *6*

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae** *attached*

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Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): Scott E. Shapiro, PA Delegation Chair State: PA

3. **Dean's signature**

The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: Therese M. Wolpaw MD, MHPE

Signatory's name and title (Please print): Therese M. Wolpaw Vice Dean Educational Affairs

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attached

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- ☐ Female
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What is your sexual orientation?

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Explain, if desired:

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Arshjot Singh Khokhar
University Manor East · Apt. 202 · Hershey, PA · 17033 · akhokhar@pennstatehealth.psu.edu · (661) 993-8050

EDUCATION

Pennsylvania State University College of Medicine; *Hershey, PA* — 2017 – present
Medical Doctorate, Expected Graduation: May 2021

University of Southern California, *Los Angeles, CA* — 2013 – 2016
B.S. Neuroscience, *magna cum laude*

HONORS/AWARDS

Bedrick Family Medical Student Research Award — 2018
Aber Merit Scholarship; *Pennsylvania State University* — 2017 – present
Dean Merit Scholarship; *University of Southern California* — 2013 – 2017

RESEARCH EXPERIENCE

Medical Student Researcher; *Pennsylvania State University* — 2017 – present
Working on projects concerning pediatric populations suffering from chronic diseases such as Sickle Cell Anemia and Neuromuscular Disease. Advisor: British Mondal

Undergraduate Research Assistant; *University of Southern California* — 2014 – 2017
Helped collect and analyze data in the search for a correlation of alcohol-induced behavior and indirect genetic effects in Drosophila. Advisor: Sergey Nuzhdin

SERVICE

LionCare; *Pennsylvania State University* — 2017 – present
Volunteered in a free clinic in Harrisburg, PA, taking histories and completing focused physical exams for in-need patients and then presenting them to attending physicians.

Child Life; *Pennsylvania State University* — 2017 – present
Spend time with kids who are admitted into the Emergency Department.

PULSE; *Pennsylvania State University* — 2017 – present
Mentorship to prospective high school students interested in the medical field. As a club, we introduce students to science concepts and ideas like professionalism.

Patient Navigation; *Pennsylvania State University* — 2017 – 2018

Emergency Medicine Southern California (EMSC); *University of Southern California* — 2015 – 2016
Providing appropriate care and medical interventions to patients on the USC campus as a volunteer healthcare provider.

LEADERSHIP

American Medical Association; *Pennsylvania State University COM Chapter President & Delegate* — 2017 – present
Represented PSU on the Legislative Action Committee for Region 6 in 2018, as well as written and reviewed multiple resolutions for AMA's MSS annual conference.

Ultrasound Educator Program; *Pennsylvania State University* — 2018 – present
Teach first year medical students the basics of ultrasound in conjunction to their anatomy course.

Emergency Medicine Interest Group; *Skills Coordinator* — 2018 – present
Scheduled and helped teach varying skills seen in the emergency room setting.

United States of America Junior Men's Field Hockey Team; *Co-Captain* — 2011 – 2014
Represented the U.S. in matches against international competition for eight years.

PRESENTATIONS

Modal, P., **Khokhar, A.**, Bascom R. End-Tidal Carbon Monoxide: A Novel Biomarker of Hemolysis in Children with Sickle Cell Disease. *Pennsylvania State University.* February 2018. — 2018

Khokhar, A., B. Foley, S. Nuzhdin. Investigating the genetic variation in reversal learning of Drosophila larvae, and the correlation between reversal learning and addiction. *University of Southern California.* April 2016. — 2016

AUTHORSHIP

Khokhar, A., Hamlin, D., Moses, T., Kim, E. Addressing the Need for Standard Evidenced-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression. *American Medical Association Medical Student Section.* 2018. — 2018

Diversity Statement

I share my middle name with about a half percent of the world population because I belong to the Sikh community. As a child, I made hour-long treks every weekend to gurudwara, a Sikh temple. It was here that I learned about my faith. Through seva, which means selfless service, my family and I donated, cooked, and served langar, a vegetarian meal. The seva was not just for the members of our congregation. I found myself serving food to people of all faiths and color. Though my Punjabi, our spoken language, is not advanced enough to read Guru Granth Sahib, our holy book, through seva I was able to learn an important pillar of my religion: service to all. Being Sikh has taught the importance of service to the community and how that service should extend to all people no matter their beliefs, socioeconomic status, or color. As a delegate, I plan to extend the concepts of service and tolerance that I learned as a practicing Sikh to the work I do for the AMA.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 and I-21 HOD meetings.
- Attend as much of the A-20 and I-21 MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2021.)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020and October 2021.)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Samyuktha (First) Ratnam (Middle) Melachuri (Last)

Address: 101 N Dithridge St Appt 1007 (Street address)

City, State, Zip: Pittsburgh (City) PA (State) 15213 (Zip)

Telephone: 4129614969 (Day) 4129614969 (Evening)

Email address: srm109@pitt.edu

Medical School: University of Pittsburgh School of Medicine

Expected graduation: 2022

AMA-MSS Region (1-7): 6

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**
2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is

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Email: mss@ama-assn.org

willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): _Scott E. Shapiro, MD Delegation Chair___State: _PA___

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): JOAN HARUZY ASSOC DEAN STUDENT AFFAIRS

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☑ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☐ Male
- ☑ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>

☐ Yes ☑ No

Explain, if desired:

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****Optional Release to External Organization Positions** – For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☐ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☑ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 1:59PM/CST.

Email: mss@ama-assn.org

Samyuktha Melachuri

101 N Dithridge St. Apt 1007 Pittsburgh PA 15213
srm109@pitt.edu Phone: (412)-961-4969

Career Goals and Objectives: to pursue a career in medicine and research in the medical field of science

Education:

University of Pittsburgh School of Medicine: May 2022
Resuscitation: Area of Concentration
Emergency Medicine Training/Bystander Training
Art of Seeing/Human Anatomy
University of Pittsburgh Graduation: April 2018
GPA: 3.8; Summa Cum Laude
Bachelor of Science (Pre-Medicine)

- Minor: Chemistry

Work/Research Experience:

Research at the University of Pittsburgh Medical School and UPMC Hospital System *(2015-Present)*

- Working with Dr. Thirumala on a series of clinical studies
- Published:
  - The Diagnostic Accuracy of Somatosensory Evoked Potentials in Evaluating New Neurological Deficits After Posterior Cervical Fusions—**Published In *Spine***
  - The Diagnostic accuracy of somatosensory evoked potentials in evaluating neurological deficits during 1036 posterior spinal fusions—**Published in *Neurological Research***
  - Risk Factors for Positioning Related Somatosensory Evoked Potential Changes in 3946 Spinal Surgeries—**Published by *Journal of Clinical Monitoring and Computing***
  - The Diagnostic accuracy of somatosensory evoked potentials in evaluating neurological deficits during lumbar interbody fusions—**Published by *Clinical Neuroscience***
  - Diagnostic Accuracy of Somatosensory Evoked Potentials in evaluating new neurological deficits after Spinal Thoracic Fusion—under review by the ***Spine Journal***
  - Diagnostic Accuracy of low threshold in pedicle screw testing during lumbar spine procedures: Implications of baseline somatosensory evoked potential responses— undergoing review by ***Spine***
- Unpublished:
  - Diagnostic Accuracy of Changes in SSEP Amplitude and Latency for Detection of Iatrogenic Injury During Posterior Cervical Spine Procedures: Evaluation of Current Alarm Criterion
  - Diagnostic Accuracy of changes in SSEP amplitude and latency during thoracic surgery
  - The diagnostic accuracy of free run electromyography to predict postoperative deficits after lumbar spine surgeries
  - Descriptive analysis on Position Related Changes
  - The Predictive value of Intraoperative Neurophysiological Monitoring to detect post-operative neurological deficit in patients with normal versus abnormal baseline recordings during cervical spine surgery
- 2018 Summer PREP Scholar at the University of Pittsburgh Medical School
  - Poster Symposium- September 25th BST South Lobby, Pittsburgh
- AMA Research Symposium: November 2018
- Presented at the 33rd Cervical Spine Research Society Conference – May 24–26, 2017 Salzburg (Austria): to a conference of 200 world renowned neurosurgeons
- Presented at the 34th Cervical Spine Research Society Conference – May 9-11, 2018 Lisbon, Portugal: to a conference of 200 world renowned neurosurgeons
- Research Leader/Manager
  - Assisting other researchers working for Dr. Thirumala with their research studies in guidance with data collection, statistical analysis, manuscript preparation, journal submission
  - In charge of the Spinal Research in the Neurosurgical and Neurophysiological Lab

Research Intern at UPMC Department of Otolaryngology *(2018-Present)*

- Working with Dr. Carl Snyderman on
  - Qualitative Improvement study on Carotid Body Tumor Resection Surgery
  - Lumosity Study determining a relationship between performance on the Lumosity application and surgical promise in medical students and residents
- 2019 Summer Deans Summer Research Scholarship at the University of Pittsburgh School of Medicine
  - Poster Symposium-September 16th, 2019 BST South Lobby, Pittsburgh

Research Intern at Nationwide Children's Hospital of Columbus: *(2018-Present)*

- Wrote the manuscript and completed statistical analysis for: The Impact of Cochlear Implantation on Speech Perception, Articulation, Language, and Vocabulary in Children with Asymmetric Sensorineural Hearing Loss
- Accepted for Podium Presentation at American Cochlear Implant Association in Florida, July 2019

Research Intern at the Children's Hospital of Pittsburgh: ***(2014-2015)***

- Worked with Dr. Gregory Kato, Hematologist/Oncologist, and Dr. Swaroop Pinto, Pediatric Hematologist/Oncologist
  - Project involved sleep studies and echocardiography to identify whether sleep apnea leads to hypertension in patients with sickle cell disease

Lillehei Heart Institute Summer Research Scholars Program: ***(Summer 2014)*** **University of Minnesota: Lillehei Heart Institute**

- Received a highly competitive, prestigious scholarship designed to expose students to several disciplines within cardiovascular disease research and its clinical applications
- Mentor: Daniel J Garry M.D. Ph.D. Professor of Medicine; St. Jude Medical Endowed Chair in Cardiology Department of Medicine; Director of the Lillehei Heart Institute, Chief of Cardiovascular Division of the University of Minnesota
- Research Project: "Analysis of Foxk1 expression during skeletal muscle regeneration." Identified the localization of transcription factor Foxk1 at various time points post cardiotoxin mediated injury in transgenic mice. Worked under the guidance of Post Doc: Marie L. Antony
  - Skills attained: immunohistochemical techniques, muscle sectioning, running PCR, microscopy, imaging, working with transgenic mice, some FACs exposure, acclimated to the basic research lab environment, familiarity with basic research literature
  - Presented research to many PI's, cardiovascular researchers, and medical doctors at the 6th Annual Cardiopalooza, created for intra-institutional collaboration and networking
  - Introduced to clinical, industrial, and academic medicine through a variety of field trips including Experimental Surgical Services and the Visual Heart Lab
- Received hands on experiences that included guided pig heart dissection, reanimation of a pig heart
- Attended weekly seminars by faculty and industry leaders

Honors Mentor Connection: ***(2012-2014)*** **Minneapolis, MN**

- Worked with Dr. Bruce Bostrom Pediatric Hematologist/Oncologist at Children's Hospitals of Minnesota **(270 hours)**
  - Researched for clinical study: "The Association Between Fasting Hypoglycemia and Methylated Mercaptopurine Metabolites in Children With Acute Lymphoblastic Leukemia" that identified the mechanisms of the chemotherapeutic drug 6-MP responsible for hypoglycemia; **published by the Pediatric Blood and Cancer Journal**
  - Presented at the Tumor Conference at the Minneapolis Children's Hospital on Wednesday, April 24th 2013
  - Clinical study "Association of Elevated AST, ALT and 6-Methyl-mercaptopurine in Children with Acute Lymphoblastic Leukemia on Mercaptopurine"
- Worked with Dr. Laura Gandrud Pediatric Endocrinologist at Children's Hospitals of Minnesota **(100 Hours)**
  - Worked on a Clinical study "A Retrospective study on Predictors for HbA1C in Children with Type 1 Diabetes Mellitus on Continuous Glucose Monitoring System" identifying the groups of children the Continuous Glucose Monitor benefits such as age, gender, ethnicity, duration of Diabetes, duration of use of sensor, method of taking insulin, BMI, HbA1C level
- Conducted 12 informational interviews with Physicians specialized in Hematology/Oncology, Cardiology, Endocrinology, and Internal Medicine
- Read 27 research publications in Hematology/Oncology

Volunteer Experience:

Shirdi Sai Ganaga Mandir: (2018-Present) Pittsburgh, PA

- Volunteer for the poor, elderly, and homeless in Pittsburgh
  - Donate old and new clothing to homeless shelters
  - Provide groceries
  - Cook and serve food
- Writing grants to get funding to maintain and complete building an orphanage and old age home in Andhra Pradesh, India

Sathya Sai Spiritual Organization: ***(2014- Present)*** **Pittsburgh, PA**

- Take care of and teach children every Saturday

Children's Hospital: ***(2015-Present)*** **Pittsburgh, PA**

- Sibling Center: take care of the siblings of patients when they are undergoing treatment
- OPALs: play with the children in Units 9A and 9B (Oncology Wards)

United Hospital: ***(2010-2014)*** **(204 hours) St. Paul, MN**

- Helped patients, families, and staff at the hospital by performing various duties in Guest Services, Patient Discharge Services, Patient Transport, Laboratory, Day Surgery, Sterile Processing, Gift Shop, and Patient Services
- Transported patients from their rooms to their vehicles to go home in-Patient Discharge Services
- Directed patients and visitors to their appointments or loved ones respectively in Guest Services
- Brought severely pained or injured patients to the ER and triage nurses in Emergency Department
- Cleaned used pre- and post-operational rooms and beds in Day Surgery

- Implemented a centrifuge system and pneumatic tubing system to deliver and receive lab specimens throughout the hospital in the Laboratory
- Gave hand massages and warm drinks to patients and guests in the Endocrine Clinic
- Helped transport inpatients to their appointments such as x rays, ultrasound, MRIs, cat scans, by moving them in motorized wheelchairs or beds in Transport Services

Woodbury Health East Nursing Home: ***(2011-2014)*** **(180 hours) Woodbury, MN**

- Assisted elderly residents by transporting them to non-denominational church and back every Sunday

Feed My Starving Children: ***(2009-2014)*** **Eagan, MN**

- Packaged food for children in poverty stricken nations

Flu Shot Drive at St. Stephen's Homeless Shelter: ***(November 2011 and September 2012)*** **Minneapolis, MN**

- Translated Spanish for doctors and the Spanish speaking patients
- Improved the accuracy of information by assisting clients with administrative paperwork

Woodwinds Hospital: ***(2011-2012)*** **(95 Hours) Woodbury, MN**

- Provided guest services for visitors and outpatients and managed the Gift shop

Minnesota Children's Museum: ***(2010-2012)*** **(240 hours) St. Paul, MN**

- Led creative arts programs, helped children in the Museum galleries, gained experience working with children, built teamwork, communication, and leadership skills
- Guided a team of ten Play Team Volunteers with their schedule and their interaction with children

Rochester Medical Camp: ***(April 2010)*** **Rochester, MN**

- Helped organize a medical camp in Rochester
- Communicated with the patients who only spoke Spanish, checked patients in, helped take blood pressure, temperature, heart rate, sight and hearing checkups

Shadowing Experience:

- Neurophysiologist: Parthasarathy Thirumala M.D. University of Pittsburgh Medical Center
  - Observed the monitoring of patient neurophysiology in surgery to prevent any damage caused by the surgery, prevent stroke, or other injury. Surgeries with neurophysiological monitoring observed:
    - Neurosurgeons: correction of scoliosis patients and the surgical teaching process for residents and fellows
    - Ear, Nose, and Throat Surgeons: the removal of a tumor from thymus
- Emergency Medicine: Dr. Joseph Yanta M.D. University of Pittsburgh Medical Center; Dr. Ankur Doshi
- Critical Care: Dr. Deanna Blissard M.D. Veterans Hospital Pittsburgh
- Ear, Nose, and Throat: Dr. Edwin Page M.D. St. Francis Hospital Columbus GA
  - Observed surgeries, including sinus and thyroidectomies, in the operating room
  - Observed the clinical interaction between Dr. Page and his patients: during ear wax removal, endoscopies, biopsies
- Pediatric Nephrologist: Yosuke Miyashita M.D. Children's Hospital of Pittsburgh:
  - Observed the clinical interaction between Dr. Miyashita and patients with urinary tract infections, kidney stones, kidney dysfunction, and hypertension
  - Observed the teaching of residents and fellows
- Pediatric Gastroentrologist: Arvind Srinath M.D. Children's Hospital of Pittsburgh:
  - Interacted with patients, saw how medical students learn in their clinical rotations
- Family Practitioner/Internal Medicine: Mary Hull M.D. UPMC Shadyside
  - Interacted with cancer patients, observed pap smear, annual OB/GYN checkup
- Emergency Department: Joseph Yanta M.D. University of Pittsburgh Medical Center Mercy
  - Observed the removal of abscesses and other acute cases in the ER
- Pediatric Hematologist/Oncologist: Bruce C Bostrom M.D. St. Paul/Minneapolis Children's Hospitals
  - Interacted with patients, looked at MRI and CAT scans, and looked at brain tumor specimens with pathologists
  - Observed the administration of chemotherapy intravenously through port-a-cath, subcutaneously through injection, and intraventricularly to reach cerebrospinal fluid by lumbar puncture
  - Attended meetings and seminars in Children's Hospital along with Dr. Bostrom
- Pediatric Endocrinologist: Laura Gandrud M.D. St. Paul/Minneapolis Children's Hospitals
  - Observed the interaction between Dr.Gandrud and children and parents with Type 1 Diabetes
- Nurse Practitioner in Endocrinology: Betsy Anderson St.Paul/Minneapolis Children's Hospitals
  - Interacted with the children in my research project to identify the effectiveness of the Continuous Glucose Monitor on different categories of children
- Radiologist: Kathryn Dusenbery M.D. University of Minnesota
  - Saw a CAT scan and its results in the abdominal area; removal of uterus to get rid of malignant tumor growth
  - Observed patient and doctor interaction in a clinical setting

Activities and Leadership:

American Medical Association:

- Positions
    - External President of University of Pittsburgh School of Medicine (2018-2020)
    - Alternate Delegate for Pennsylvania Medical Student Section (2018-2019)
    - Delegate for Pennsylvania Medical Student Section
    - Allegheny County Medical Society Delegate
- Conferences
    - Interim Meeting In Washington, DC November 2018
    - Annual MSS Meeting In Chicago, IL June 6-8th
    - House of Delegates in Chicago, IL June 8-12th

Interview Coordinator for UPSOM *(2018-2019)*

- Organize and Conduct interviews for medical school applicants at Pitt Med

Sami Melachuri Diversity Statement:

Think of chocolate syrup in milk on a humid summer day; it mixes almost effortlessly. However, this same brown liquid could be a chocolate chunk on a cold wintery day: relentless and hard to mesh into a cup of milk. This was my childhood. One brown, Indian girl amongst a school full of Caucasian students in Minnesota. I had different interests from my peers: a nerd with "too much focus on school" for a teenager, a dancer who danced to foreign music that no one understood at the talent show, a kid who ate meals that could be smelled from classrooms away. Soon, another Indian girl, a friend from childhood, joined my high school. Unlike me, she smoothly mixed in with the masses and even became popular. It blew my mind. Just a few years ago, she was just like me: starkly different from those around us. I realized there are two kinds of people: people who change to fit in and people who stick to whom they are. Not that one type of person is superior or inferior, but I learned that people are different, and we need to cherish these differences. Otherwise, its easy to lose one's self. I took these experiences into college and medical school: trying to interact with those different from me, learning about people's cultures and beliefs. These same differences that once cast me out, made me cherish the diversity around me. Till this day, I am fascinated by how people think, feel, and act differently. Non-judgmental curiosity led me to make life long friends and gave me a wholistic understanding of the world around me.

I am a part of The University of Pittsburgh School of Medicine Admissions committee and run the student interviews section of admissions. We strive to admit diverse classes, full of students from different educational, racial, sexual, and religious backgrounds. One of Pitt Med's pillars is diversity. Diversity training is integrated into our curriculum. We attend lectures on how to interact with those different from us, be it socioeconomic status, race, religion, sexual orientation, or disabilities, amongst others. This is followed by small group sessions where we talk to patients who have faced discrimination and advise us on the best ways to interact with patients like them in a nonharmful and empathetic manner.

Just like chocolate syrup on a hot, humid summer day versus a thick slab of chocolate on a crisp frost-bitten day, I have had the experience of fitting in and sticking out like a sore thumb. My experiences helped me learn to become inclusive and open to new ideas. Not only do I currently contribute to diversity in the AMA, like we all do, but I can also foster and support diversity as a Medical Student Section Delegate for Pennsylvania.

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Hussein (First) A (Middle) Antar (Last)

Address: 88 Wigwam Hill Dr. (Street address)

City, State, Zip: Worcester (City) MA (State) 02048 (Zip)

Telephone: 781 927 4539 (Day) (Evening)

Email address: Hussein.antar@umass.med.edu.

Medical School: University of Massachusetts Medical School

Expected graduation: 2021

AMA-MSS Region (1-7): 7

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**
2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Alain Chaoui

Signatory's name and title (Please print): Alain A. Chaoui, MD, FAAFP State: MA

Chair, MA Physician Delegation to the AMA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: SM Chi

Signatory's name and title (Please print): Sonia Chimienti MD. Assoc Dean Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions <u>are optional</u>:

Are you Hispanic? ☐ Yes ☒ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☒ Other: Middle Eastern
- ☐ Prefer not to respond

What is your gender identity?

- ☒ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☒ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

<u>Would you describe yourself as having a disability/being differently-abled?</u>

☐ Yes ☒ No

Explain, if desired:

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Email: mss@ama-assn.org

Curriculum Vitae

Hussein Antar

Address: 88 Wigwam Hill Dr., Worcester, MA 01605
Email: Hussein.antar@umassmed.edu
Phone: (781) 927 - 4539

Education:

University of Massachusetts Medical School: Worcester, MA *Aug 2017*
M.D. Candidate, Anticipated 2021

Northeastern University: Boston, MA *2012-2017*
B.S. in Biology and Health Science (*Cum Laude*)

Poster Presentations & Publications:

- Original Research Manuscript *Accepted Sep 2019*
  - **Antar H**, Tsikata E, Zhang J, et al. Analysis of neuroretinal rim by age, race, and gender using high-density three-dimensional spectral domain optical coherence tomography. *J Glaucoma.*
- Original Research Manuscript *Aug. 2019*
  - Adler R, Ferguson WJ, **Antar H**, et al. Transformation support provided remotely at scale generated cost savings among a large nationwide cohort of optometrists. *Ann Fam Med.* 2019;17(Suppl 1):S33-S39. Doi: 10.1370/afm.2423.
- Original Research Manuscript *Nov. 2018*
  - Poon Y. **Antar H**, Tsikata E, et al. Effects of age, race, and ethnicity on the optic nerve and peripapillary region using spectral-domain OCT 3D volume scans. *Transl Vis Sci Technol.* 2018;7(6):12. Doi: 10.1167/tvst.7.6.12.
- 2018 UMMS Summer Research Poster Session *Aug 2018*
  - Poster presented at the annual University of Massachusetts Medical School Summer Research Fair, entitled "*Remote Practice Transformation Support Improved Cost and Quality of Case Among a Nation-wide Group of Optometrists*"

Research & Laboratory Experience:

- *May-Jul 2018* University of Massachusetts Medical School, Commonwealth Medicine
  - David Polakoff, MD, MSc, Chief Medical Officer and Associate Dean, Director, Center for Health Policy and Research
  - Brian Bjoern, MD, Associate Director of Practice Transformation

- Project: Research on quality improvement, cost savings, and barriers encountered by a national cohort of clinicians enrolled in the Centers for Medicare & Medicaid Services' *Transforming Clinical Practices Initiative*.

- *2012-2017* Northeastern University, Biology Department
- Yunrong Chai, PhD, Associate Professor of Microbiology
- Prepare and perform experiments on antibiotic resistance and biofilm formation in *S. aureus* and *B. subtilis.*
- Prepare plates, inoculate cells, perform assays, and other laboratory techniques.

- *2016* Massachusetts Eye and Ear Infirmary, Glaucoma Service
- Teresa C. Chen, MD, Chief Quality Officer, Ophthalmology
- Recruit patients from the glaucoma clinic into a large study on diagnostic imaging capabilities. Obtain informed consent, perform Spectralis OCT scans, analyze images, and bill for scans.
- Design and execute a study on the effect of age, gender, and race on a novel neuroretinal rim parameter in healthy adults, including setting inclusion and exclusion criteria, organizing a list of eligible patients, calculating parameters using custom-made software, compiling statistical analysis, and reporting the results in a scientific manuscript.

Honors & Awards:

- *2017-2019* Kristen M. Ettensohn Memorial Scholarship*;* University of Massachusetts Medical School
- *2012- 2017* Dean's Scholarship; Northeastern University
- *2016- 2017* Alpha Epsilon Delta Honor Society
- *2015* Charles C. Ely Scholarship; Charles C. Ely Trust
  - Awarded to a male student on the basis of academic merit, character, and leadership abilities.
- *2012* W. Duane Lockard Scholarship; Dr. Martin Luther King, Jr. Memorial Scholarship of Greater Attleboro
  - Awarded to students who exemplify the values of Dr. King.
- *2012* Joseph C. Megan, Jr. Scholarship; Foxboro High School
  - Awarded to a student exemplifying good scholarship and extracurricular and community activities.

Leadership Experience:

- *Jun 2019* Delegate, American Medical Association 2019 Annual Meeting; Chicago, IL.
  - Represent Region 7 of the AMA's Medical Student Section at the House of Delegates meeting. Reviewed and discussed resolutions on various topics

and testified on conflicts of interest in FDA advisory committees.

- *2018 – 2019* OrgMed; University of Massachusetts Medical School
    - Co-leader of the organized medicine group which represents the American Medical Association and Massachusetts Medical Society
- *2018 - 2019* Global Health Optional Enrichment Elective; University of Massachusetts Medical School
    - Co-leader of the elective which introduces global health medical topics to students to increase their interest in global health.
- *2018 – 2019* Governing Councilor for the Massachusetts Medical Society's Medical Student Section
    - Represent the University of Massachusetts Medical School at monthly meetings.
- *Nov 2018* Delegate, American Medical Association Medical Student Section 2018 Interim Meeting; National Harbor, MD.
    - Reviewed and discussed resolutions as a representative of the University of Massachusetts Medical School.
- *Jun 2018* Alternate Delegate, American Medical Association Medical Student Section 2018 Annual Meeting; Chicago, IL.
    - Reviewed and discussed resolutions as a representative of the University of Massachusetts Medical School.
- *Apr 2018* Delegate, Massachusetts Medical Society 2018 Annual Meeting; Boston, MA.
    - Reviewed and discussed resolutions as a representative of the University of Massachusetts Medical School.
- *Mar 2018* Medical Student Advocacy and Regional Conference (MARC), American Medical Association; Washington. D.C.
    - Learned about the role of medical students in advocacy efforts and participated in meetings with legislative and health policy aides for Senators Elizabeth Warren and Ed Markey and Congressman Joseph Kennedy, III, pushing for specific bills addressing issues such as graduate medical education funding, gun violence, and the opioid crisis.
- *Dec 2017* Delegate, Massachusetts Medical Society 2017 Interim Meeting; Waltham, MA.
    - Reviewed and discussed resolutions as a representative of the University of Massachusetts Medical School.
- *2014-2017* NU Lebanese Society; Northeastern University
    - President of the cultural club aiming to increase awareness of Lebanese culture and integrate Lebanese students on campus
- *2013-2017* Bouvé Ambassador; Northeastern University Bouvé College of Health Sciences
    - Served as a student panelist at events with prospective students

Professional & Volunteer Experience:

- 2019 – present AMA-MSS Committee on Long Range Planning

- *2017- 2019* Volunteer, Worcester Free Clinic Coalition
    - Helped obtain patient histories and perform physical exams
- *2016-2017* Resident Assistant, Northeastern University – Housing & Residential Life
    - Supervised 58 residents and advised them on academic, career, and personal matters, mediated conflict, and encouraged collaboration between residents.
    - Organized, marketed, and lead educational programs to promote community and personal development.
- *2014- 2015* Ophthalmic Assistant, Massachusetts Eye and Ear Infirmary, Neuro-Ophthalmology Service
    - Performed Humphrey Visual Field testing, optical coherence tomography, and fundus photography on patients.
    - Assisted in clinic workflow, patient correspondence, and scheduling appointments.
- *2015* Team Captain, Relay for Life; Northeastern University

Professional Memberships:

2017-Present American Medical Association
2017-Present Massachusetts Medical Society

Application for AMA-MSS Regional Delegate and Alternate- 2020

Note: You must be an AMA Member to serve as a Regional Delegate or Alternate.

ALL APPLICATION MATERIALS MUST BE RECEIVED BY EMAIL BY OCTOBER 4, 2019 AT 11:59PM/CST.
Email: mss@ama-assn.org

Expectations for Regional Delegates and Alternates

Regional Delegates and Alternates are expected to:

- Fully attend the A-20 (June 6-10, 2020) and I-20 (Nov 14-17, 2020) HOD meetings.
- Attend as much of the A-20 (June 4-6, 2020) and I-20 (Nov 12-14, 2020) MSS Assembly meetings as feasible.
- Actively participate in the MSS Resolution Review process, which includes providing feedback on MSS resolutions and mentoring newer members. (Major time commitments during April 2020 and September 2020)
- Actively participate in the HOD Resolution Review process. (Major time commitments during May 2020 and October 2020)
- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Parth (First) D (Middle) Trivedi (Last)

Address: 64 Bregman Ave (Street address)

City, State, Zip: New Hyde Park (City) NY (State) 11040 (Zip)

Telephone: 516-732-6451 (Day) (Evening)

Email address: parth.trivedi@icahn.mssm.edu

Medical School: Icahn School of Medicine at Mount Sinai

Expected graduation: 2021

AMA-MSS Region (1-7): 7

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: _____

Signatory's name and title (Please print): JOHN KENNEDY MD, CHAIR State: NY

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: _____

Signatory's name and title (Please print): Alicia Hurtado, MD
Interim Senior Associate Dean for Student Affairs

Note to applicants: Your application will not be considered complete, and you will not be eligible for election, until you have submitted the required signatures.

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Diversity and Demographics

To attract the most diverse pool of candidates possible, we request the following self- reported diversity statement and optional demographic information. This information will be used in the internal deliberation of candidates and may be reported in aggregate form only. For applicants to organizations outside the AMA: this information will only be released to the organization to which you are seeking appointment (1) if you are the AMA's selected nominee and (2) if you provide permission to do so. **

7. **Candidate's Diversity Statement**. Please describe how you will bring diversity to the position for which you are applying.

8. **Demographics.** The following questions are optional:

Are you Hispanic? ☐ Yes ☑ No

What is your self-identified race?

- ☐ White
- ☐ Black
- ☑ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander
- ☐ Other:
- ☐ Prefer not to respond

What is your gender identity?

- ☑ Male
- ☐ Female
- ☐ Transgender
- ☐ Other:
- ☐ Prefer not to respond

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☑ Heterosexual/Straight
- ☐ Other:
- ☐ Prefer not to respond

Would you describe yourself as having a disability/being differently-abled?
☐ Yes ☑ No
Explain, if desired:

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****Optional Release to External Organization Positions –** For AMA nomination opportunities for external leadership positions: To further our mission of ensuring diverse representation, the AMA asks nominees if they would like to share the diversity statement and optional demographic information they have provided to us with the external organization for the position for which they have applied.

Please indicate your decision below:

☑ No. I choose NOT to authorize the AMA to share this diversity statement and optional demographic information on this form to any external organization.

☐ Yes. I authorize the AMA to share the diversity statement and optional demographic information I have provided in this application with the external organization to which I am applying for a position. I understand that the AMA will only include this optional diversity information if I am selected as a nominee.

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Email: mss@ama-assn.org

Parth D. Trivedi

14R-4 50 E. 98th St. pdt32@cornell.edu 64 Bregman Ave
New York, NY 11029 516-732-6451 New Hyde Park, NY 11040

EDUCATION

Icahn School of Medicine at Mount Sinai, New York, NY — Expected Gradua. on: 2021
MD, MSCR Candidate

Cornell University, College of Engineering, Ithaca, NY — Gradua on: May 2016
B.Sc. in Chemical and Biomolecular Engineering, Tau Beta Pi, Magna Cum Laude

SELECT LEADERSHIP EXPERIENCE

American Medical Association; Icahn School of Medicine at Mount Sinai — Jan 2017 - ongoing
Chapter President (Jan 2017 - Jan 2019)
Alternate Region Delegate (Oct 2018 - ongoing)
House of Delegates Coordination Committee member (Jan 2019 - ongoing)
RefComm E Team Lead (May 2019 - June 2019)

CEQM programming presenter (see Oral Presentations below) (Nov 2017)

Medicine for Migration; Icahn School of Medicine at Mount Sinai — Oct 2018 - Nov 2019
· Grassroots campaign speaking out against proposed changes to public charge status; spearheaded by UCSF and Mount Sinai students
· Successfully organized a "Na onal Week of Advocacy" that spanned 25 medical schools

EHHOP Consulting Group; Icahn School of Medicine at Mount Sinai — Feb 2017 - ongoing
Project Lead: Bridges Collaborative Care Clinic (Oregon)
· Engage SRFCs na onwide on a variety of issues including medico-legal ma ers, workflow op miza on, and volunteer recruitment strategies
· Highlight Project: Aided in Bridges CCC's successful launch in Nov 2017; 16 pa ent/month capabili es, soon to expand to 32

Student High Value Care Committee (sHVCC); Icahn School of Medicine at Mount Sinai — Aug 2016 - ongoing
· Medical student group focused on teaching and implemen ng quality improvement in healthcare

Sinai Health Innovation Program (SHIP); Icahn School of Medicine at Mount Sinai — April 2017 - ongoing
Founding Member, Logistics Coordinator, Instructor
· Week long summer camp exposing high school students (with a focus on those from underserved communi es) to principles of innova on, engineering, and entrepreneurship in healthcare

Science Olympiad at Cornell; Cornell University — Sept 2014 - Feb 2016
Founding Member, Treasurer, Volunteer Coordinator
· Hosted 30+ high schools at Cornell's Science Olympiad invita onals

PUBLICATIONS

Lau I, Maximilian Png CY, **Trivedi P**, Finlay D. Use of the distal radial artery remnant for autogenous radial-cephalic wrist fistula a. er radial artery harvest for coronary artery bypass gra. ing. J Vasc Surg Cases Innov Tech. 2018;4(2):73-75.

POSTER PRESENTATIONS

Trivedi P, Guo J, Friedman SL. Protocadherin-7 Spliceoform Expression in Hepa c Stellate Cells. Poster presented at 2018 Icahn School of Medicine Medical Student Research Day. New York, NY. March 15, 2018.

Raja A, **Trivedi P**, Dhamoon MS. Discharge against medical advice among neurological pa□ents: characteris□cs and outcomes. Poster presented at 2018 Icahn School of Medicine Medical Student Research Day. New York, NY. March 15, 2018.

Trivedi P, Raja A, Nabeel I. Development of a Return to Work Tool for Primary Care Providers for Low Back Pain Pa□ents: Pilot Study Assessment. Poster presented at 2017 AAPMR Annual Assembly. Denver, CO. Oct 12-15, 2017.

Tai D, Miner A, Mauiyuran H, Blazejowskyj A, Israilov S, **Trivedi P**, et al. Client Workflow of a Student-Run Free Clinic Consul ng Group. Poster presented at 2018 Society for Student Run Free Clinics Annual Conference. Omaha, NE. Feb 24-25, 2018.

PENDING PUBLICATIONS AND PRESENTATIONS

Trivedi PD, Raja A, Dhamoon MS. Discharge against medical advice among neurological pa□ ents: characteris□cs and outcomes. Under review: Journal of Neurology, Neurosurgery, and Psychiatry.

Maia Kayal, Michael Plietz, Anam Rizvi, Marlana Radcliffe, Alexa Riggs, Clara Yzet, Emily Tixier, **Parth Trivedi**, et al. Incidence and Risk Factors of Inflammatory Condi ons of IPAA Under review: Gastroenterology.

ONGOING QUALITY IMPROVEMENT PROJECTS

· Improving adherence to IBD guidelines in Mount Sinai faculty and fellow clinics
· Improving adherence to guidelines in Mount Sinai liver clinic
· Evalua□on of strategies to decrease no-shows to Mount Sinai's student run free clinic (SRFC) specialty referrals program

ORAL PRESENTATIONS

Introduction to Writing a Grant Proposal
New York Student Run Free Clinic Conference; New York, NY Oct 28, 2017

Comparative Study of International Health Systems – CEQM Educational Programming
American Medical Association Interim Meeting; Honolulu, HI Nov 10, 2017
· Compara□ve study US, Canadian, **Singaporean** (personal contribu on), UK, and Japanese health systems

Improving Inpatient Bowel Regimens Through Evidence-Based Medicine
Mount Sinai Hospital Department of Medicine Grand Rounds; New York, NY Dec 6, 2016; May 16, 2017
Mount Sinai Hospital Quality Improvement Council Presentation; New York, NY Feb 13, 2017
· Demonstrated a 44% reduc on in docusate orders by Department of Medicine; successful expansion to other departments and hospitals in the Mount Sinai network (Mount Sinai St. Luke's)

A case of radiocephalic fistula after radial artery harvest
New England Society of Vascular Surgery; Boston, MA
Sept 9, 2017

TEACHING EXPERIENCE

Teaching Assistant at Cornell University; Ithaca, NY Aug 2014 - May 2016
BioMG 1350 (x3), ChemE 2880 (x2), ChemE 3240, ChemE 3900, ChemE 5430
Teaching Assistant at Icahn School of Medicine at Mount Sinai; New York, NY Aug 2017 - Dec 2017
Structures (Anatomy, Histology, Embryology); Molecular, Cellular, and Genomic Foundations of Medicine (MCG)
· Conducted weekly recita□on sec ons, hosted office hours (all)
· Designed and graded problem set/quiz/exam problems (Cornell University courses)
· Training, oversight, and assessment of Junior TAs (BioMG 1350)

Skills: MatLab, sta□s□cal software (R, SAS), Excel, HTML/CSS, beginner-level Python, mathema□cal modeling, data analysis, laboratory techniques, teamwork, strong interpersonal skills, teaching, learning

As a child of immigrants that grew up in Elmhurst, Queens, I was fortunate to have grown up in an environment that exposed me to a variety of cultures while letting me learn more about the two that define me - my parents' heritage, as well as my American nationality by birth. Elmhurst is considered one of the most ethnically diverse places on Earth, and growing up there was an incredibly American experience in a somewhat paradoxical sense, given that little of the culture in the area originates from this country but everyone shares a common belief in the American Dream.

In addition to my upbringing, the fact that I'm a first generation physician, an aspiring researcher, and a chemical engineer by training, all contribute to my unique perspectives on medicine. As a medical student, I've sought to contribute to the community as a volunteer clinician for low-SES and at-risk populations, as an advocate for those same communities, and as a researcher exploring issues (liver disease, NAFLD/NASH, cirrhosis, HCC) that disproportionately affect low SES and immigrant populations. In the future, I hope to continue explore these topics, both from the bench science perspective as well as from the clinical perspective, and how they disproportionately affect members of my ethnic community.

I believe a combination of all these experiences helps me bring diversity to the delegate position, and I hope that in the future I can continue contributing diversity in upbringing, training, and thought to organized medicine.

Application for AMA-MSS Regional Delegate and Alternate- 2020

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- Provide testimony per MSS Caucus discussion on the Virtual Reference Committee and during in-person Reference Committee, as well as to the HOD as necessary.
- Advocate for MSS priorities with state societies, specialty societies, and other AMA Sections.

Name: Leah (First) Yuan (Middle) (Last)

Address: 669 Massachusetts Ave, Apt 1 (Street address)

City, State, Zip: Boston (City) MA (State) 02118 (Zip)

Telephone: (513) 693-6499 (Day) (Evening)

Email address: leahyuan@bu.edu

Medical School: Boston University School of Medicine

Expected graduation: 2022

AMA-MSS Region (1-7): 7

In addition to this application, all applicants must submit the following items:

1. **A current curriculum vitae**

2. **Signature of State Delegation Chair or State Medical Society Executive Vice President**
   The elected AMA Delegate from a Medical Student Region will be a representative of and be seated with the state delegation representing the student's medical school. Alternate Delegates will also be seated with the Delegate's state delegation. The signature of the AMA HOD State Delegation Chair

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or State Medical Society EVP verifies that the state delegation is aware of your candidacy and is willing to accept and include you as part of the delegation.

Note: The signature does not imply funding to attend the meeting. However, per House of Delegates action on BOT Report 19 (I-00), state societies are strongly encouraged to provide full financial support to student delegates elected from the Regions.

Signature of State Delegation Chair or State Medical Society EVP: Alain Chaoui

Signatory's name and title (Please print): Alain A. Chaoui, MD, FAAFP State: MA
Chair, MA Physician Delegation to the AMA

3. **Dean's signature**
The signature of your dean or preceptor is required to verify that you are a student in good standing, and that you will be given time off to attend all portions of the Annual and Interim Meetings of the AMA House of Delegates.

Signature of Dean or Preceptor: P. Garg

Signatory's name and title (Please print): PRIYA GARG, Associate Dean of Medical Education

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Email: mss@ama-assn.org

Current Address:
669 Massachusetts Ave, Apt 1
Boston, MA 02118

LEAH YUAN
leahyuan@bu.edu / (513) 693-6499

Permanent Address:
4960 Chestnut Hill Dr.
Mason, OH 45040

EDUCATION

Boston University School of Medicine *Boston, MA*
M.D. Candidate *August 2018 – May 2022 (anticipated)*

- **Awards:** Deans Scholarship

Washington University in St. Louis *St. Louis, MO*
Bachelor of Arts, Biology *August 2013 – May 2017*

- **Awards:** Deans List, 2013-2017

RESEARCH

Boston University School of Medicine – Boston, MA *May 2019*
Mentor: Ariel Hirsch, MD, Associate Professor in the Department of Radiation Oncology

- Explore the pre-medical gap year trends by examining gap-year-related posts on Reddit, a news aggregation and online discussion website, via keyword and content analysis

Boston University School of Medicine – Boston, MA *March 2019*
Mentor: Ariel Hirsch, MD, Associate Professor in the Department of Radiation Oncology

- Analyze the scholarly impact of student authorship on research

Washington University School of Medicine in St. Louis – St. Louis, MO *March 2015 – August 2016*
Mentor: Maria Remedi, PhD, Assistant Professor of Medicine and Cell Biology & Physiology

- Study KATP channel mutations that are linked to neonatal diabetes and hyperinsulinism and identify mechanisms by which target mutations affect insulin secretion

EMPLOYMENT

Boston University School of Medicine Tutoring – Boston, MA *August 2019 - Present*
Tutor

- Aid first-year medical school students with their curricular courses one-on-one

Dermatology Associates, P.C. – Boston, MA *June 2017 – June 2018*
Medical Assistant

- Assist physicians in general dermatology visits as well as in Mohs micrographic surgery

Total Access Urgent Care – St. Louis, MO *June 2016 – May 2017*
Technician and Scribe

- Help physicians by scribing and ordering tests while the physician is assessing the patient
- Aid in administering medications and performing labs that the physician requests

ACTIVITIES

Asian Pacific American Medical Student Association (APAMSA) *March 2019 - Present*
Boston University Chapter Chair

- Coordinate events to raise awareness about healthcare disparities within Asian populations
- Advocate for important Asian healthcare issues with APAMSA chapters across the USA

Association of American Medical Colleges (AAMC) *March 2019 - Present*
Regional Delegate

- Represent the students in conversations about medical education
- Implement and support new ideas to improve student wellness and education

American Medical Association (AMA) *March 2019 - Present*
Boston University Chapter Chair

- Coordinate policymaking and networking events within Boston University and in Massachusetts

Massachusetts Medical Society Medical Student Section – Waltham, MA *May 2019 - Present*
Membership Chair

- Encourage MMS and AMA membership in Massachusetts medical students
- Organize networking and social events for students

Pre-Clerkship Curriculum Subcommittee – Boston, MA *October 2018 - Present*
Student Representative

- Represent the students in discussions regarding the improvement of medical education
- Vote on important curriculum changes that are proposed over the next four years

PROFESSIONAL AFFILIATIONS

American College of Physicians (2018 – Present**)**

American Medical Association (2018 – Present)

Asian Pacific American Medical Student Association (2019 – Present)

Association of American Medical Colleges (2018 – Present)

Massachusetts Medical Society (2018 – Present)

SKILLS

Conversational in Spanish

Professional Working Proficiency in Mandarin

Proficient in Python, SPSS