



MEMBERSHIP
MOVES
MEDICINE™

2019 AMA Senior Physicians Section Interim Meeting
Manchester Grand Hyatt, San Diego
November 16, 2019

Table of Contents

Agenda
Meeting logistics
Policy materials
Education Materials
Announcements

*For the best user experience, please download a copy of this handbook
to your personal device*



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)

Agenda

Senior Physicians Section Assembly & Education Program

11:00 am – 12:00 pm - SPS Assembly

12:00 – 1:30 pm – SPS Education Program, *'The Impact of Vision and Hearing Loss in the Senior Population – Why Seeing and Hearing are Believing'*

For the best user experience, please download a copy of this handbook to your personal device

Senior Physicians Section

Assembly Meeting Agenda

Saturday, November 16 (11 am – Noon)

Manchester Grand Hyatt San Diego

Room: Grand Hall C

A buffet lunch will be served at 11:30 am on a first-come, first-served basis.

The Senior Physicians Section (SPS) Assembly is open to any senior physician 65 years of age and older as well as those interested in senior physician issues.

Saturday, November 16

11:00 – 11:10 am	Welcome and Introductions Louis Weinstein, MD, Chair <ul style="list-style-type: none"> • Introduction of Governing Council Members • SPS Mission Statement • Updates on CME Report 1-I-18, Competency of Senior Physicians – (Referred) & Resolution 316-A-19, Medical Student Debt – (Adopted as amended) 	TAB A
11:10 – 11:20 am	Discussion on part time work for senior physicians and professional liability insurance Speaker: Louis Weinstein, MD, Chair Questions/feedback will be requested from audience members.	TAB B
11:20 – 11:30 am	Consideration of positions available for senior physicians through the Veterans' Health Administration Speaker: Jenny L. Boyer, MD, JD, PhD, AMA-SPS, Officer At-large. Questions/feedback will be requested from audience members.	TAB C
11:30 am – 12:00 pm	I-19 HOD Handbook Review / SPS Grid of Items for Discussion <i>Barbara S. Schneidman, MD, MPH, Delegate & Luis T. Sanchez, MD, Alternate Delegate</i>	TAB D
12:00 – 1:30 pm	Immediately following the Assembly Meeting, the Senior Physicians Section (SPS) will host a joint education program, ' <i>The Impact of Vision and Hearing Loss in the Senior Population – Why Seeing and Hearing are Believing</i> ' Speakers: <ul style="list-style-type: none"> • Bobby Mukkamala, MD, AMA Board of Trustees • Mihir Y. Parikh, MD, La Jolla, California Moderator & Facilitators: <ul style="list-style-type: none"> • Louis Weinstein, MD, Chair, AMA-SPS Governing Council • James F. Burdick, MD, Chair-Elect, AMA-SPS Governing Council 	TAB E
	Additional items of interest for senior physicians during the I-19 meeting.	TAB F

New items of business related to the Section's mission may be introduced and points of personal privilege, as time allows. Please come prepared to introduce new items of business related to the Section's mission that would be pertinent to SPS for comment.

The SPS GC will look at two signature areas to explore at the upcoming Assembly meeting with senior physicians.

Part time work for senior physicians and professional liability insurance – *Louis Weinstein, MD, Chair, Senior Physicians Section*

1. With the noted increase in the shortage of working physicians along with the increase in physician burnout, a potential solution is to increase the number of senior physicians who desire to work part-time relieving the stress on both the system and the providers. Strategies in the workplace need to be developed to allow senior physicians with an active medical license to more easily join the work force on a limited basis.
 - For seniors who desire a part-time employment, a major impediment is the inability to obtain liability insurance at a reasonable cost. The SPS can develop strategies that would allow states or institutions to implemented liability policies at a reasonable cost. One strategy to consider is to use slotting for a liability policy that allows a physician to rotate in and out of a slot to which the policy is assigned. A second strategy is to develop job sharing with 2 or 3 physicians making a single FTE and filling one liability insurance slot. A third strategy for the SPS is to develop a clearing house to match physicians seeking part-time employment with available positions or locations.

Department of Veteran Affairs – Opportunities for Senior Physicians – *Jenny Boyer, MD, JD, PhD, Officer At-Large, Senior Physicians Section*

2. The SPS is working to advertise part time VA positions at medical facilities through the JAMA Career Center. The VA is seeking fully licensed physicians to serve Veteran patients in various clinical areas. This program would allow senior physicians an opportunity to give back to the Veteran community by serving in a volunteer role to deliver health care services. We would be interested in your thoughts on how best to advertise these positions to senior physicians who might have an interest in volunteering.
 - There might be a possibility of putting together several part time positions for full time opportunities. The full time FTE for individual facilities would meet the unique needs for various types of physician expertise
 - If some positions were in telemedicine, then we would be able to implement some specialty care much more expediently.
 - We would be contributing access to care for veteran patients along with meaning and purpose for senior AMA physicians. This proposal would meet both the mission of the VA and the AMA.

Meeting Logistics

Wi-Fi: 2019INTERIM

Password: 2019INTERIM

Manchester Grand Hyatt hotel map

Marriott Marquis hotel map

Meeting app information

*For the best user experience, please download a copy of this handbook
to your personal device*

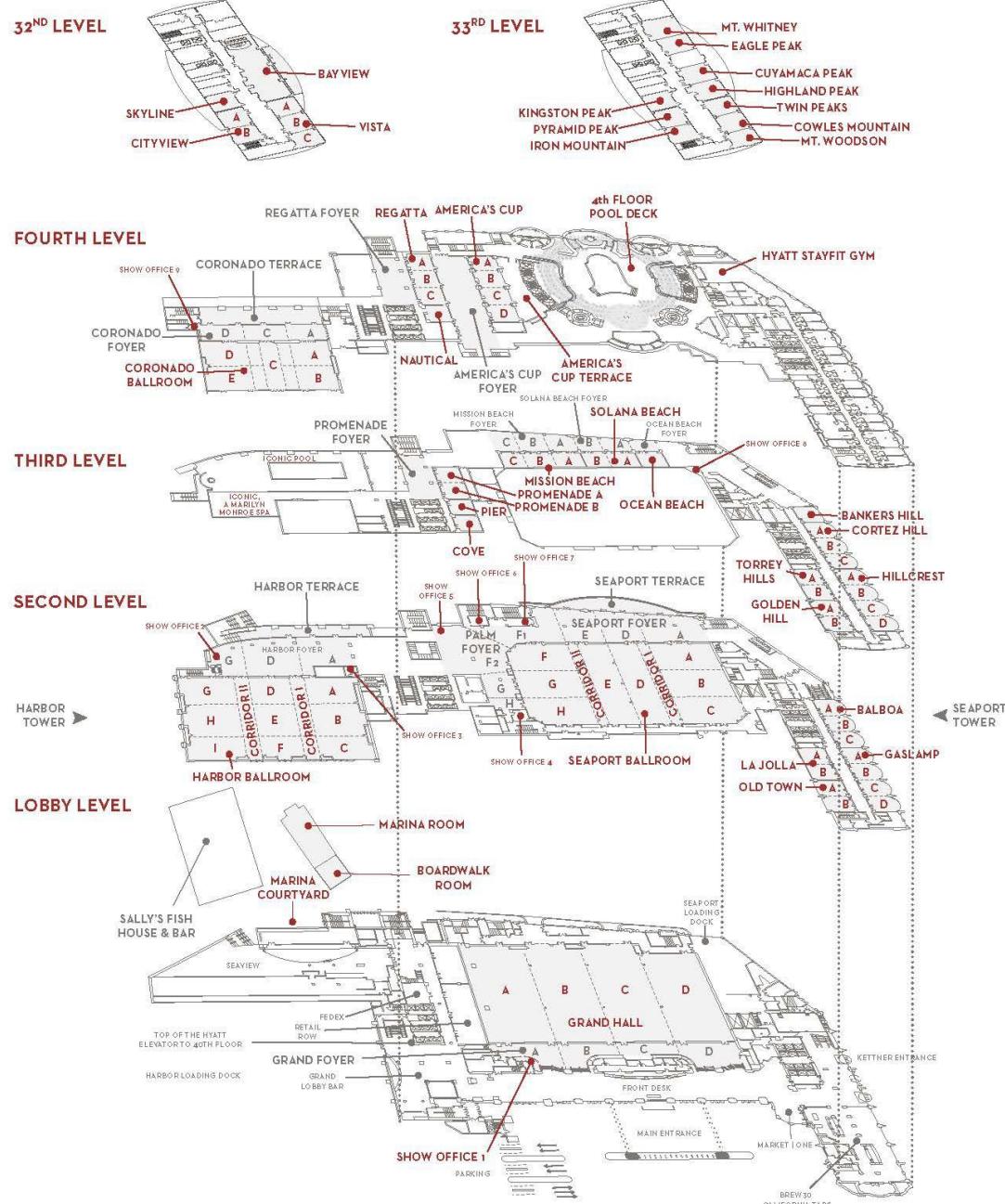


MEMBERSHIP MOVES MEDICINE™

Manchester Grand Hyatt

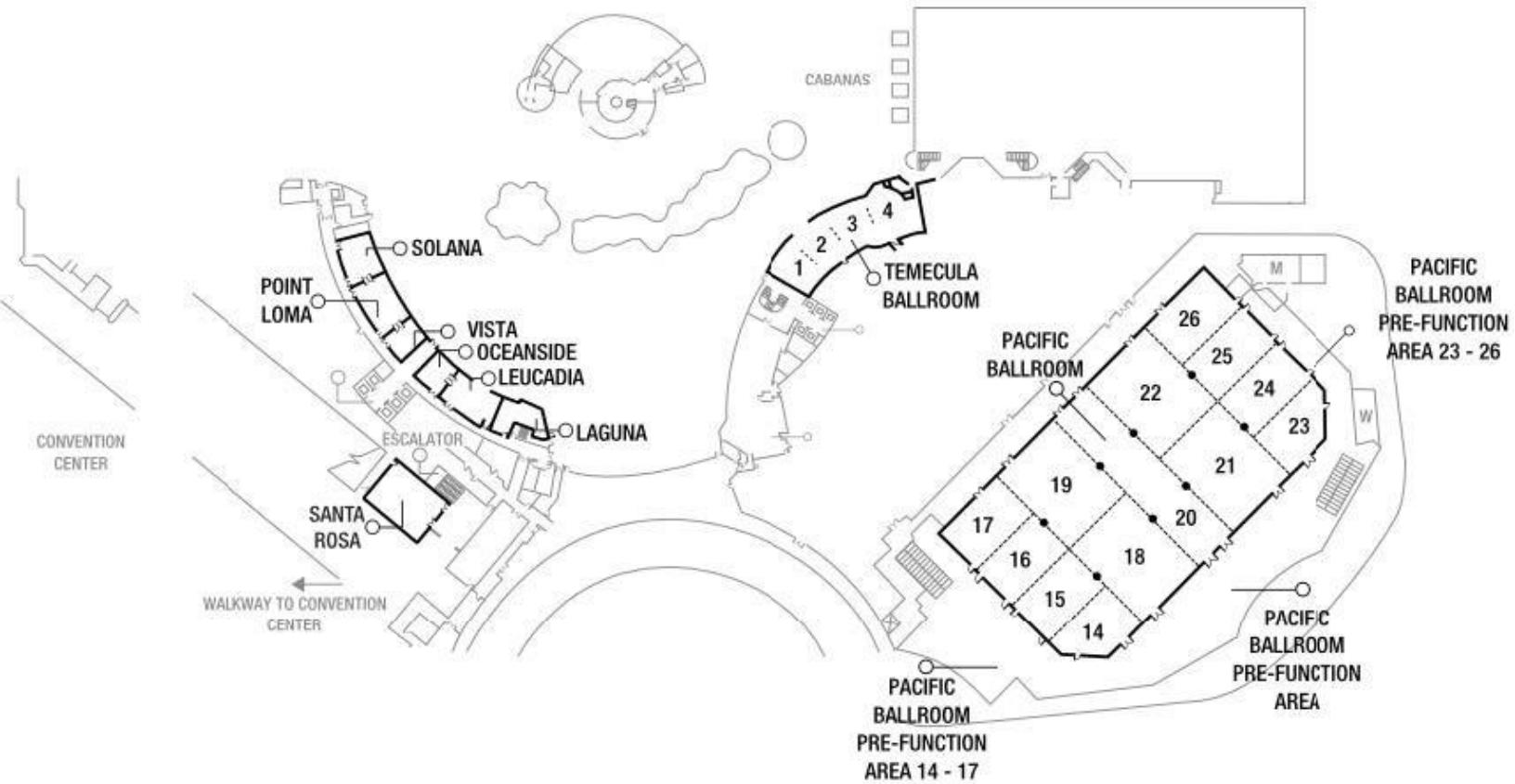
FLOOR PLAN

All Floors



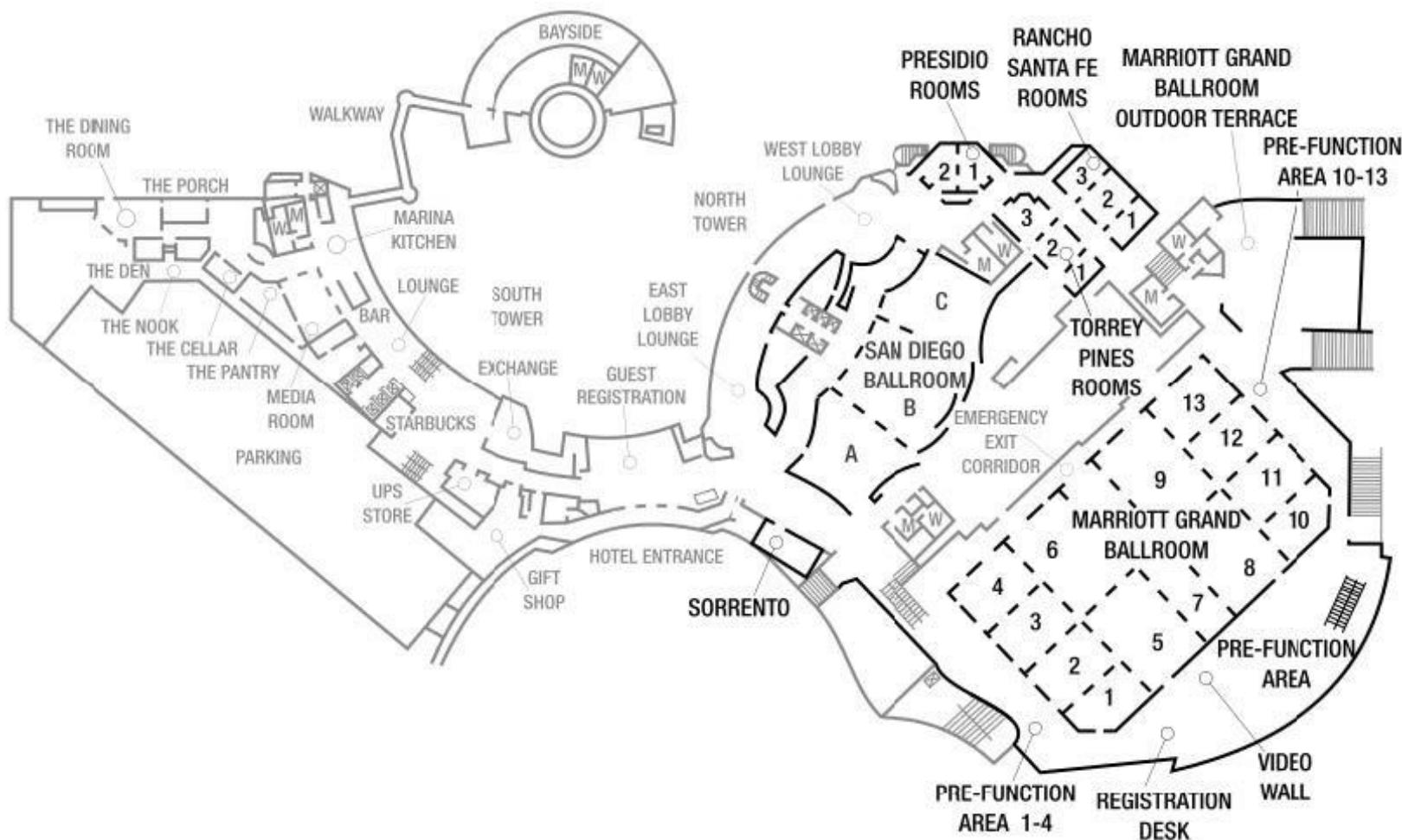
For the best user experience, please download a copy of this handbook to your personal device

Marriott Marquis
Level One



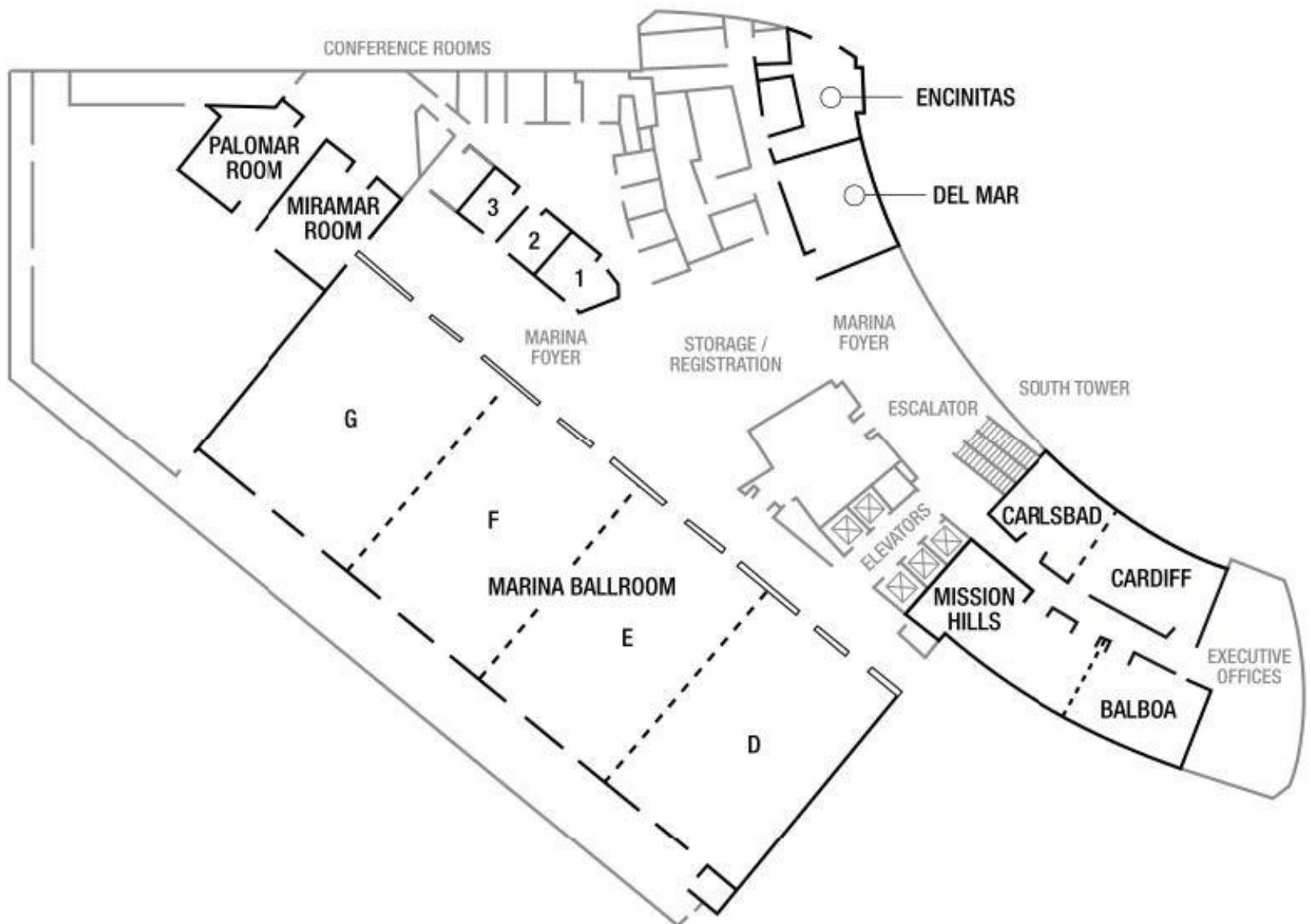
*For the best user experience, please download a copy of this handbook
to your personal device*

Marriott Marquis
Lobby Level



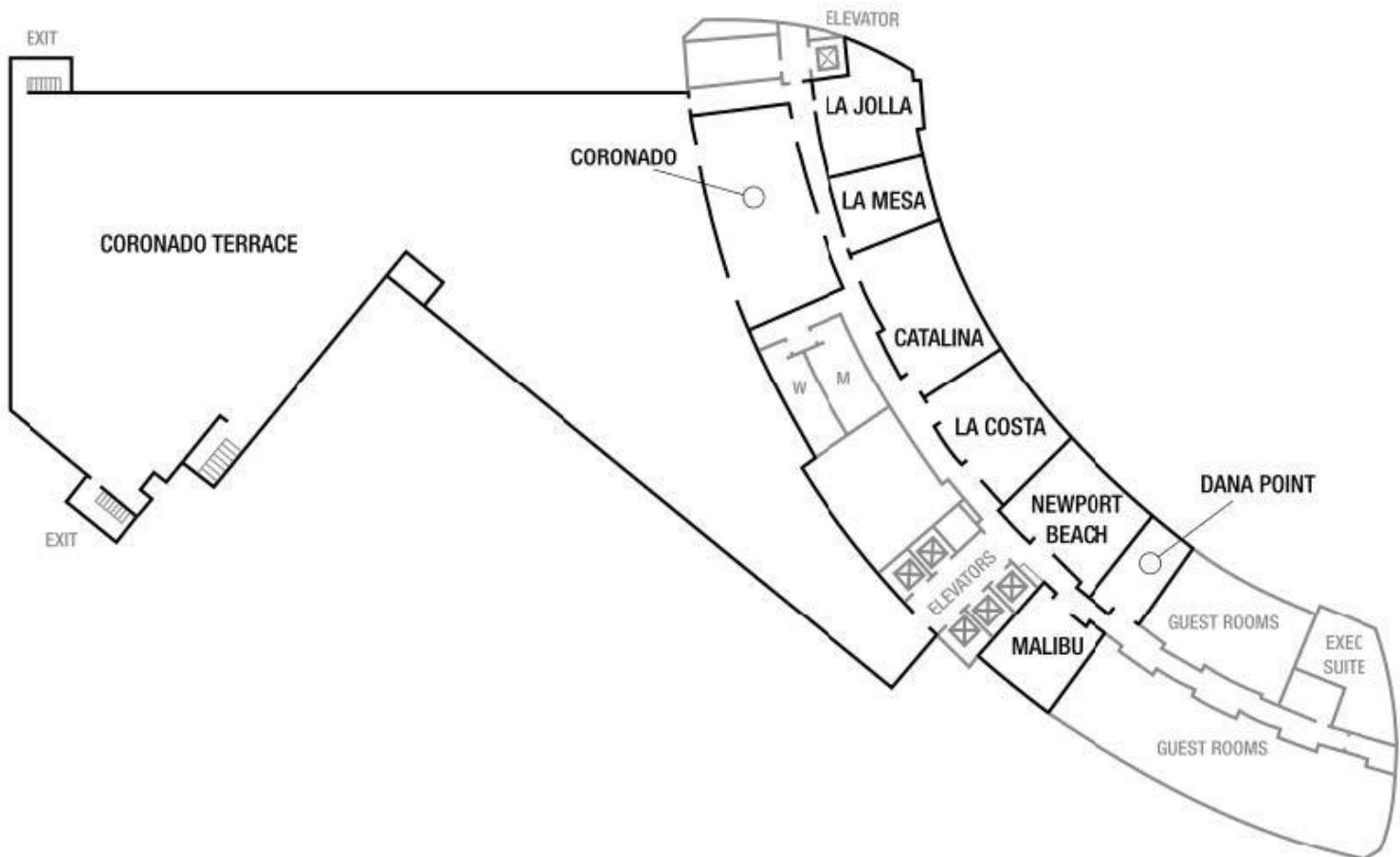
*For the best user experience, please download a copy of this handbook
to your personal device*

Marriott Marquis
South Tower - Level 3



*For the best user experience, please download a copy of this handbook
to your personal device*

Marriott Marquis
South Tower - Level 4



*For the best user experience, please download a copy of this handbook
to your personal device*

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:

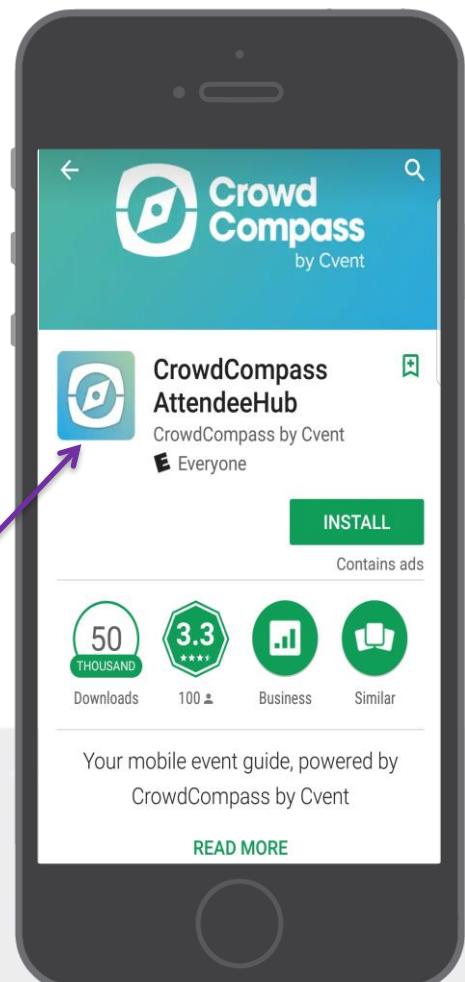
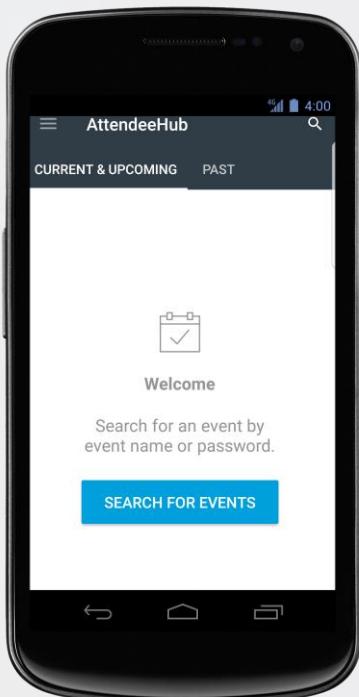
<https://event.crowdcompass.com/amainterim19>



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.



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

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

- **I-19 HOD Handbook Review / SPS Grid of Items for Discussion**
- **Parliamentary Procedure Quick Tips**

House of Delegates Items of Discussion:

- **CEJA Report 1** – Competence, Self-Assessment and Self Awareness (Amendments to C&B)
- **CEJA Report 2** – Amendment to E-1.2.2, “Disruptive Behavior by Patients” (Amendments to C&B)
- **Res 001** – Support for the Use of Psychiatric Advance Directives – (Amendments to C&B)
- **Res 007** – Addressing the Racial Pay Gap in Medicine (Amendments to C&B)
- **Res 203** – Support Expansion of Good Samaritan Laws (B)
- **Res 206** – Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians (B)
- **Res. 209** – Federal Government Regulation and Promoting Patient Access to Kidney Transplantation (B)
- **Res 210** – Federal Government Regulation and Promoting Renal Transplantation (B)
- **Res 305** – Ensuring Access to Safe and Quality Care for our Veterans (C)
- **CMS 1** – Established Patient Relationships and Telemedicine (J)
- **CMS 4** – Mechanisms to Address High and Escalating Pharmaceutical Prices (J)
- **Res 802** – Ensuring Fair Pricing of Drugs Developed with the US Government (J)
- **Res 804** – Protecting Seniors from Medicare Advantage Plans (J)
- **Res 805** – Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard (J)
- **Res 806** – Support for Housing Modification Policies (J)
- **Res 807** – Addressing the Need for Low Vision Aid Devices (J)
- **Res 808** – Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs (J)
- **CSAPH 3** – Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (K)
- **Res. 923** – Support Availability of Public Transit Systems (K)

New items of business related to the Section’s mission may be introduced and points of personal privilege, as time allows. Please come prepared to introduce new items of business related to the Section’s mission that would be pertinent to SPS for comment.

*For the best user experience, please download a copy of this handbook
to your personal device*

I-19 HOD Handbook Review – Senior Physicians Section

Ref Comm	Resolution/ Report	Title	Recommendation/Resolve	Support/ Not Support/ Monitor/Comments
Amendments to C&B	CEJA 01	Competence, Self-Assessment and Self-Awareness	<p>Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:</p> <p>The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills.</p> <p>However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.</p> <p>To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:</p> <ul style="list-style-type: none"> (a) Cultivate continuous self-awareness and self-observation. (b) Recognize that different points of transition in professional life can make different demands on competence. (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations. 	Support

I-19 HOD Handbook Review – Senior Physicians Section

			<p>(d) Seek feedback from peers and others.</p> <p>(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.</p> <p>(f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.</p> <p>(g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.</p> <p>Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.</p> <p>Fiscal Note: Minimal - Less than \$500</p>	
Amendments to C&B	CEJA 2	Amendment to E-1.2.2, "Disruptive Behavior by Patients"	<p>In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; Opinion 1.2.2, "Disruptive Behavior by Patients," be amended by addition and deletion as follows; and the remainder of this report be filed:</p> <p>The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting <u>their the</u> dignity and rights <u>of both patients and physicians</u>.</p> <p>Disrespectful, <u>or</u> derogatory, <u>or</u> prejudiced, language or conduct, <u>or</u> prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek <u>or provide</u> care,</p>	Support

I-19 HOD Handbook Review – Senior Physicians Section

		<p>and create an environment that strains relationships among patients, physicians, and the health care team.</p> <p>Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:</p> <p class="list-item-l1">(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those <u>they target who are targeted</u>.</p> <p class="list-item-l1">(b) Always treat patients with compassion and respect.</p> <p class="list-item-l1">(c) <u>Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.</u></p> <p class="list-item-l1">(d) <u>In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician's personal characteristics.</u></p> <p class="list-item-l1">(e) <u>Consider accommodating a patient's request for an alternative physician when the request derives from the patient's adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.</u></p> <p class="list-item-l1">(f) <u>In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient's expressed preference.</u></p>	
--	--	---	--

I-19 HOD Handbook Review – Senior Physicians Section

			<p>(eg) Terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudiced manner whose volitional behavior is disrespectful, derogatory, or prejudiced only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care <u>when that is feasible</u>.</p> <p><u>Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:</u></p> <p>(h) <u>Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.</u></p> <p>(i) <u>Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.</u></p> <p>(j) <u>Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients.</u></p> <p>(k) <u>Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.</u></p> <p>Fiscal Note: Minimal – less than \$1,000</p>	
Amendments to C&B	Res. 001 (MSS)	Support for the Use of Psychiatric Advance Directives	<p>RESOLVED, That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (New HOD Policy)</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Support
Amendments to C&B	Res. 007 (MSS)	Addressing the Racial Pay Gap in Medicine	<p>RESOLVED, That our American Medical Association support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further</p>	Support

I-19 HOD Handbook Review – Senior Physicians Section

			RESOLVED, That our AMA support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy) Fiscal Note: Minimal – less than \$1,000	
B	Res. 203 (MSS)	Support Expansion of Good Samaritan Laws	<p>Support Expansion of Good Samaritan Laws</p> <p>RESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows:</p> <p>911 Good Samaritan Laws, D-95.977</p> <p>Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; <u>and</u> (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; <u>and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws.</u> (Modify Current HOD Policy)</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Support
B	Res. 206 (IMGs)	Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians	<p>RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Support
B	Res. 209 (American Society of Transplant Surgeons)	Federal Government Regulation and Promoting Patient Access to Kidney Transplantation	<p>RESOLVED, That our American Medical Association engage US government regulatory and professional organ transplant organizations to advance patient and physician-directed care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA actively promote regulatory efforts to assure physician and patient involvement in the design of any ESRD federal demonstration program (Directive to Take Action); and be it further</p>	Support (lump together w/Res. 210)

I-19 HOD Handbook Review – Senior Physicians Section

			<p>RESOLVED, That our AMA actively advocate for legislative and regulatory efforts which create incentives for dialysis providers, transplant centers, organ donors, and ESRD patients to increase organ donation and improve access to kidney transplantation in the United States. (Directive to Take Action)</p> <p>Fiscal Note: Modest – between \$1,000 and \$5,000</p>	
B	Res. 210 (American Society of Transplant Surgeons)	Federal Government Regulation and Promoting Renal Transplantation	<p>RESOLVED, That our American Medical Association actively advocate for US organ transplant legislative and regulatory policies that would advance kidney transplantation by modifying or eliminating arbitrary transplant center outcomes measures that currently discourage sound clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many patients. (Directive to Take Action)</p> <p>Fiscal Note: Modest – between \$1,000 and \$5,000</p>	Support (lump together w/Res. 209)
C	Res. 305 (YPS)	Ensuring Access to Safe and Quality Care for our Veterans	<p>RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:</p> <p>Ensuring Access to <u>Safe and Quality</u> Care for our Veterans H-510.986</p> <ol style="list-style-type: none"> 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans. 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner. 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration. 	Monitor

I-19 HOD Handbook Review – Senior Physicians Section

			<p>5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.</p> <p>6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify HOD Policy)</p> <p>Fiscal Note: Minimal - less than \$1,000</p>	
J	CMS 1	Established Patient Relationships and Telemedicine	<p>1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action)</p> <p>2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy)</p> <p>3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and “curbside consultations.” (Reaffirm HOD Policy)</p> <p>Fiscal Note: Less than \$500.</p>	Monitor
J	CMS 4	Mechanisms to Address High and Escalating Pharmaceutical Prices	<p>1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:</p>	Support (CMS 4 lumped w/Res. 802 & 805)

I-19 HOD Handbook Review – Senior Physicians Section

		<ul style="list-style-type: none">a. The arbitration process should be overseen by objective, independent entities;b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;e. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision;f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity;g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; andh. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision. (New HOD Policy) <p>2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:</p> <ul style="list-style-type: none">a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;c. The use of any international drug price index or average should preserve patient access to necessary medications; and	
--	--	--	--

I-19 HOD Handbook Review – Senior Physicians Section

			<p>d. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy)</p> <p>3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy)</p> <p>4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy)</p> <p>5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)</p> <p>6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy)</p> <p>7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)</p> <p>Fiscal Note: Less than \$500</p>	
J	Res. 802 (MSS)	Ensuring Fair Pricing of Drugs Developed with the United States Government	<p>RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows:</p> <p>Pharmaceutical Costs, H-110.987</p> <p>1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic</p>	Support (CMS 4 lumped w/Res. 802 & 805)

I-19 HOD Handbook Review – Senior Physicians Section

		<p>manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.</p> <p>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.</p> <p>3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.</p> <p>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.</p> <p>5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.</p> <p>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.</p> <p>7. Our AMA supports legislation to shorten the exclusivity period for biologics.</p> <p>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.</p> <p>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.</p> <p>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</p>	
--	--	--	--

I-19 HOD Handbook Review – Senior Physicians Section

			<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><u>14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as an individual solution or in conjunction with other approaches. (Modify Current HOD Policy)</u></p> <p>Fiscal Note: Minimal - less than \$1,000</p>	
J	Res. 804 (Indiana)	Protecting Seniors from Medicare Advantage Plans	<p>RESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy)</p> <p>Fiscal Note: Modest – between \$1,000 and \$5,000</p>	Support
J	Res. 805 (IMG's)	Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard	<p>RESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it</p>	Support (CMS 4 lumped w/Res. 802 & 805)

I-19 HOD Handbook Review – Senior Physicians Section

			<p>RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)</p> <p>Fiscal Note: Modest – between \$1,000 and \$5,000</p>	
J	Res. 806 (MSS)	Support for Housing Modification Policies	<p>RESOLVED, That our American Medical Association support legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the disabled or soon to be disabled; and (c) other persons with physical and/or mental disabilities. (New HOD Policy)</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Support
J	Res. 807 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)	Addressing the Need for Low Vision Aid Devices	<p>RESOLVED, That our American Medical Association support legislative and regulatory actions promoting insurance coverage and adequate funding for low vision aids for patients with visual disabilities. (Directive to Take Action)</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Support
J	Res. 808 (American Academy of Physical Medicine & Rehabilitation)	Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs	<p>RESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the seat elevation and standing features in their power wheelchairs on an individual basis according to the National Coverage Determination (NCD) for mobility</p>	Support

I-19 HOD Handbook Review – Senior Physicians Section

			<p>assistance equipment (MAE), activate the existing Healthcare Common Procedure Coding System (HCPCS) codes for seat elevation and standing feature in power wheelchairs, and determine appropriate reimbursement levels for these codes in order to facilitate access to these important benefits for Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further</p> <p>RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing feature through its administrative authority, our AMA advocate before Congress to support legislation that will clarify the DME benefit to include coverage, coding and reasonable reimbursement of standing feature and seat elevation in power wheelchairs for appropriate Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments. (Directive to Take Action)</p> <p>Fiscal Note: Modest – between \$1,000 - \$5,000</p>	
K	CSAPH 03	Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (Res. 414-A-19)	<p>The Council recommends that the following recommendation be adopted in lieu of Resolution 414-A-19, and the remainder of the report be filed.</p> <p>The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis-derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)</p> <p>Fiscal Note: Minimal – less than \$1,000</p>	Monitor

I-19 HOD Handbook Review – Senior Physicians Section

K	Res. 923	Support Availability of Public Transit Systems	<p>RESOLVED, That our American Medical Association amend current policy H-135.939, "Green Initiatives and the Health Care Community," by addition and deletion as follows:</p> <p>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; <u>and (5) the establishment, expansion, and continued maintenance of affordable, reliable public transportation;</u> and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA amend current policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion as follows:</p> <p>The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; <u>and (5) advocates that health be considered one of the goals in transportation planning and policy development including but not</u></p>	Monitor
---	----------	--	---	---------

I-19 HOD Handbook Review – Senior Physicians Section

		<p><u>limited to the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Modify Current HOD Policy)</u></p> <p>Fiscal Note: Minimal – less than \$1,000.</p>	
--	--	--	--

Appendix E: Parliamentary Procedure Quick Tips
Based on AIP Standard Code of Parliamentary Procedure

Type of Motion

		Procedures				
		May Interrupt Speaker?	Requires a Second?	Is motion debatable?	May be Amended?	Vote Needed?
Table of Precedence of Motions						
Privileged	Adjourn the meeting	No	Yes	Yes (Restricted)	Yes	Majority
	Recess the meeting	Yes	Yes	Yes (Restricted)	Yes	Majority
	Point of personal privilege	Yes	No	No	No	None
Incidental	Motions					
	Appeal a decision by the Speaker	Yes	Yes	Yes	No	Majority
	Suspend the Rules	No	Yes	No	No	Two-thirds
	Consider informally	No	Yes	No	No	Majority
	Requests					
	Point of order	Yes	No	No	No	None
	Parliamentary inquiry	Yes	No	No	No	None
	Divide the question	No	No	No	No	None
Subsidiary	Divide the House	Yes	No	No	No	None
	Motions					
	Object to consideration	No	Yes	Yes (Restricted)	No	Three-fourths
	Table**	No	Yes	No	No	Two-thirds
	Close debate	No	Yes	No	No	Two-thirds
	Limit/extend debate	No	Yes	Yes (Restricted)	No	Two-thirds
	Postpone consideration of an item to a certain time	No	Yes	Yes (Restricted)	Yes	Majority
	Have an item referred for decision	No	Yes	Yes (Restricted)	Yes	Majority
Main	Have an idea referred for report	No	Yes	Yes (Restricted)	Yes	Majority
	Amend a motion	No	Yes	Yes	Yes	Majority
	Specific main motions					
	a. Introduce business (The Main Motion)	No	Yes	Yes	No	Majority
	b. Adopt in-lieu-of	No	Yes	Yes	No	***
	Amend a previous action	No	Yes	Yes	No	***
	Recall	No	Yes	Yes	No	Majority
	Reconsider	Yes*	Yes	Yes (Restricted)	No	Majority
	Rescind (a main motion)	No	Yes	Yes	No	Majority

*May interrupt the proceedings but not another speaker

** In order only after item is referred to reference committee and until the House takes final action on the item

***Same vote as required for original item. For example, if the motion related to a bylaw change that required a two-thirds vote, the motion to adopt in- lieu- of would require the same.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-19

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: Kathryn L. Moseley, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The expectation that physicians will provide competent care is central to medicine. This
2 expectation shaped the founding mission of the American Medical Association (AMA) and runs
3 throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the
4 privilege of self-regulation granted to medicine by society [5]. The profession promises that
5 practitioners will have the knowledge, skills, and characteristics to practice safely and that the
6 profession as a whole and its individual members will hold themselves accountable to identify and
7 address lapses [6-9].

8
9 Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined
10 what the commitment to competence means as an ethical responsibility for individual physicians in
11 day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this
12 topic to develop ethics guidance for physicians.

13
14 **DEFINING COMPETENCE**
15

16 A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional
17 assessments of physicians' technical knowledge and skills. However, this report is not concerned
18 with matters of technical proficiency assessed by medical schools and residency programs,
19 specialty boards (for purposes of certification), or hospital and other health care organizations (e.g.,
20 for privileging and credentialing). Such matters lie outside the Council's purview.

21
22 The ethical responsibility of competence encompasses more than knowledge and skill. It requires
23 physicians to understand that as a practical matter in the care of actual patients, competence is fluid
24 and dependent on context. Importantly, the ethical responsibility of competence requires that
25 physicians at all stages of their professional lives be able to recognize when they are and when they
26 are not able to provide appropriate care for the patient in front of them or the patients in their
27 practice as a whole. For purposes of this analysis, competence is understood as "the habitual and
28 judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values,
29 and reflection in daily practice for the benefit of the individual and the community being served"
30 and as "developmental, impermanent, and context dependent" [10].

31
32 Moreover, the Council is keenly aware that technical proficiency evolves over time—what is
33 expected of physicians just entering practice is not exactly the same as what is expected of mid-
34 career physicians or physicians who are changing or re-entering practice or transitioning out of

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 active practice to other roles. Each phase of a medical career, from medical school through
2 retirement, carries its own implications for what a physician should know and be able to do to
3 practice safely and to maintain effective relationships with patients and with colleagues.
4

5 The concept that informs this report differs as well from the narrower definition of competence as
6 the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion
7 of competence that encompasses deeper aspects of wisdom, judgment and practice that enable
8 physicians to assure patients, the public, and the profession that they provide safe, high quality care
9 moment to moment over the course of a professional lifetime.
10

11 FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

12

13 Health care institutions and the medical profession as a whole take responsibility to regulate
14 physicians through credentialing and privileging, routinely testing knowledge (maintenance of
15 certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
16 action against physicians who fail to meet expectations for competent, professional practice.
17 However, the better part of the responsibility to maintain competence rests with physicians’
18 “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
19 to maintain a level of competence commensurate with [their] clinical roles” [11].
20

21 Self-assessment has thus become integral to many appraisal systems [5, 10, 12-16]. Yet clinicians
22 and trainees tend to assess their peers’ performance more accurately than they do their own—for
23 example, those who perform in the bottom quartile tend to over-estimate their abilities, while those
24 in the top quartile tend to under-estimate themselves [5,12,13,17].
25

26 Self-assessment involves an interplay of factors that can be complicated by personal characteristics
27 (e.g., gender, ethnicity, or cultural background); by lack of insight or ability to be self-observant in
28 the moment; and by external factors, such as the purpose of self-assessment [12,18]. The published
29 literature also indicates that interventions intended to enhance self-assessment may seek different
30 goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting
31 appropriate change in learning activities, or improving clinical practice or patient outcomes [12].
32

33 Thus self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe,
34 high quality care. Feedback from third parties is essential [19]. However, physicians can be hesitant
35 to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of
36 concern that soliciting feedback could adversely affect their relationships with those whom they
37 approach [20]. They may also question the accuracy and credibility of the assessment process and
38 the data it generates [21]. And they are not sure how to use information that is not congruent with
39 their self-appraisals [20].
40

41 To be effective, feedback must be valued by those being assessed as well as by those offering
42 assessment [14]. When there is tension between the stated goals of assessment and the implicit
43 culture of the health care organization or institution, assessment programs can too readily devolve
44 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
45 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
46 (“360° reviews”), for example, are generally better suited to providing feedback on communication
47 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
48 understand and use [14]. High quality feedback will come from multiple sources; be specific and
49 focus on key elements of the ability being assessed; address behaviors rather than personality or
50 personal characteristics; and “provide both positive comments to reinforce good behavior and
51 constructive comments with action items to address deficiencies” [22]. Beyond such formal

1 mechanisms, physicians should welcome and seek out informal input from colleagues. They should
2 be willing to offer timely comments to colleagues as well.

3
4 One study among physicians and trainees found that participants interpreted and responded to
5 multiple types of information, such as cognitive and affective data, from both formal and informal
6 sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or
7 throughout the day”:

8
9 I think we do a lot of it without thinking of it as reflection. We do it every day when we look at
10 a patient’s chart. You look back and see the last visit, “What did I do, or should I have done
11 something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-
12 assessment or self-reflection, but we do it dozens of times a day [23].

13
14 EXPERTISE & EXPERT JUDGMENT

15
16 On this broad understanding of competence, physicians’ thought processes are as important as their
17 knowledge base or technical skills. Thus, understanding competence requires understanding
18 something of the nature of expertise and processes of expert reasoning, themselves topics of
19 ongoing exploration [24,25,26,27].

20
21 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
22 automatic resources and to transition appropriately to a greater reliance on effortful processes when
23 needed” [24], a practice described as “slowing down.” Knowing when to slow down and be
24 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To
25 respond to the unexpected events that often arise in a clinical situation, the physician must
26 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
27 transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts
28 an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
29 serves as a critical marker for intraoperative surgical judgment [24].

30
31 *Influences on Clinical Reasoning*

32
33 Physicians’ skills of clinical reasoning develop through education, training, and experiences. Every
34 physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
35 differ from the analytical and investigative processes of their colleagues in innumerable ways.
36 Nonetheless, all physicians are susceptible to certain common pitfalls in reasoning, notably relying
37 unduly on heuristics and habits of perception, and succumbing to overconfidence.

38
39 Physicians use time-saving cognitive short cuts (heuristics) to help identify and categorize relevant
40 information. But such short cuts can also mislead physicians to miscategorize information based on
41 seeming similarity or to place too much weight “on examples of things that come to mind easily
42 [28]. Other common cognitive missteps can derail clinical reasoning as well, including
43 misperceiving a coincidental relationship as a causal one, or the tendency to remember information
44 transferred at the beginning or end of an exchange but not information transferred in the middle
45 [28,29,30].

46
47 Like every other person, physicians can also find themselves prone to conscious or unconscious
48 habits of perception or biases. They may allow unquestioned assumptions based on a patient’s race
49 or ethnicity, gender, socioeconomic status, or health behavior, for example, to shape how they
50 perceive the patient and how they engage with, evaluate, and treat the individual [31]. Physicians
51 may fall victim to the tendency to seek out information that confirms established expectations or

1 dismiss contradicting information that does not fit into predetermined beliefs [28]. These often
2 inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or
3 testing that then leads to a misdiagnosis or the wrong treatment.

4
5 So too, despite their extensive training, physicians, like all people, are often poor at identifying the
6 gaps in their knowledge [28,30]. They may consider their skills to be excellent, when, in fact, their
7 peers have identified areas for improvement [30]. Overconfidence in one's abilities can lead to
8 suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of
9 others, or not acknowledging one's limits [28,30].

10
11 Physicians should be aware of the information they do and do not have and they acknowledge that
12 many factors can and will influence their judgment. They should keep in mind the likelihood of
13 diseases and conditions and take the time to distinguish information that is truly essential to sound
14 clinical judgment from the wealth of possibly relevant information available about a patient. They
15 should consider reasons their decisions may be wrong and seek alternatives, as well as seek to
16 disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in
17 which assumptions may color their reasoning and not allow expectations to govern their
18 interactions with patients.

19
20 Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming
21 aware of areas in which their skills are not at their strongest and seeking additional education or
22 consulting with colleagues, physicians can enhance their practice and best serve their patients.

23
24 **FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS**

25
26 Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally
27 conceived has significant shortcomings, several scholars have argued that a different understanding
28 of self-assessment is needed, along with a different conceptualization of its role in a self-regulating
29 profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's
30 weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit
31 practice in areas in which one has limited competence, to help set appropriate learning goals, and to
32 identify areas that "should be accepted as forever outside one's scope of competent practice" [32].
33 Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence"
34 and to "set appropriately challenging learning goals" that push the boundaries of the physician's
35 knowledge [32].

36
37 If self-assessment is to fulfill these functions, physicians need to reflect on past performance to
38 evaluate not only their general abilities but also specific completed performances. At the same
39 time, they must use self-assessment predictively to assess how likely they are to be able to manage
40 new challenges and new situations. More important, physicians should understand self-assessment
41 as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in
42 the moment is critical to physicians' ethical responsibility to practice safely, at the top of their
43 expertise but not beyond it.

44
45 Self-awareness, in the form of attentive self-observation, alerts physicians when they need to direct
46 additional cognitive resources to the immediate task. For example, among surgeons, knowing when
47 to "slow down" during a procedure is critical to competent professional performance, whether that
48 means actually stopping the procedure, withdrawing attention from the surrounding environment to
49 focus more intently on the task at hand, or removing distractions from the operating environment
50 [25].

1 Physicians should also be sensitive to the ways that interruptions and distractions, which are
2 common in health care settings, can affect competence in the moment [34,35], by disrupting
3 memory processes, particularly the “prospective memory”—i.e., “a memory performance in which
4 a person must recall an intention or plan in the future without an agent telling them to do so”—
5 important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to
6 help reduce the number or type of interruptions and distractions and mitigate their impact on
7 medical errors [37].
8

9 A key aspect of competence is demonstrating situation-specific awareness in the moment of being
10 at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking
11 things up, consulting a colleague, or deferring from taking on a case can all be appropriate
12 responses when physicians’ self-awareness tells them they are at the limits of their abilities. The
13 capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of
14 competence broadly understood:
15

16 Safe practice in a health professional’s day-to-day performance requires an awareness of when
17 one lacks the specific knowledge or skill to make a good decision regarding a particular patient
18 This decision making in context is importantly different from being able to accurately rate
19 one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that
20 self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
21 self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and
22 continuously monitoring one’s ability to effectively solve the current problem [32].
23

24 Self-aware physicians discern when they are no longer comfortable handling a particular type of
25 case and know when they need to obtain more information or need additional resources to
26 supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—
27 the death of a loved one or other family crisis, or the reorganization of their practice, for example—
28 may be affecting their ability to provide care appropriately at a given time. They recognize when
29 they should ask themselves whether they should postpone care, arrange to have a colleague provide
30 care, or otherwise find ways to protect the patient’s well-being.
31

32 Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of
33 course. In some circumstances, self-awareness may be impaired to the point that individuals are not
34 aware of, or deny, their own health status and the adverse effects it can or is having on their
35 practice. In such circumstances, individuals must rely on others—their personal physician,
36 colleagues, family, social acquaintances, or even patients—to help them recognize and address the
37 situation. Physicians have a responsibility to one another and to patients to promote health within
38 the physician community, a responsibility that extends to intervening when a colleague’s ability to
39 practice safely is compromised [E-9.3.2]. Physicians who are unable to recognize that they are
40 impaired due to cognitive disability or other illness are not necessarily blameworthy or unethical,
41 unless they decline to address their condition and modify their practice once others have drawn
42 attention to their inability to continue practicing medicine safely.
43

44 MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME
45

46 For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their
47 professional careers. This ideal holds not just over the course of a sustained clinical practice, but
48 equally when physicians re-enter practice after a hiatus, transition from active patient care to roles
49 as educators or administrators, or take on other functions in health care. Self-assessment and self-
50 awareness are central to achieving that goal.

1 A variety of strategies is available to physicians to support effective self-assessment and help them
2 cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day
3 practice. One such strategy might be to create a portfolio of materials for reflection in the form of
4 written descriptions, audio or video recording, or photos of encounters with patients that can
5 provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve
6 practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized
7 examinations, they are drawn from one’s actual work and require self-reflection [15].
8

9 As noted above, to be effective, self-assessment must be joined with input from others. Well-
10 designed multi-source feedback can be useful in this regard, particularly for providing information
11 about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
12 response that elicits feedback about how well one maintains trust and professional relationships
13 with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
14 tool that can have practical value in helping to correct poor behavior and, just as important,
15 consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
16 feedback will not have the rigor of a validated tool but can accomplish similar ends.
17

18 Reflective practice, that is, the habit of using critical reflection to learn from experience, is
19 essential to developing and maintaining competence across a physician’s practice lifetime [38]. It
20 enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional
21 culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
22 assessed, and that it can be developed, but also that the habit can be lost over time with increasing
23 years in practice [38].
24

25 “Mindful practice”—being fully present in everyday experience and aware of one’s own mental
26 processes (including those that cloud decision making) [39]—sustains the attitudes and skills that
27 are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
28 behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined
29 negative emotions, failure of imagination, and literal-mindedness can do likewise. Physicians can
30 cultivate mindfulness in myriad ways; e.g., through meditation, keeping a journal, reviewing videos
31 of encounters with patients, or seeking insight from critical incident reports [39].
32

33 “Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that
34 pervades all aspects of practice, including being present with the patient, solving problems,
35 eliciting and transmitting information, making evidence-based decisions, performing technical
36 skills, and defining their own values” [39].
37

38 RECOMMENDATION

39

40 Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the
41 following be adopted and the remainder of this report be filed:
42

43 The expectation that physicians will provide competent care is central to medicine. It
44 undergirds professional autonomy and the privilege of self-regulation granted by society. To
45 this end, medical schools, residency and fellowship programs, specialty boards, and other
46 health care organizations regularly assess physicians’ technical knowledge and skills.
47

48 However, as an ethical responsibility competence encompasses more than medical knowledge
49 and skill. It requires physicians to understand that as a practical matter in the care of actual
50 patients, competence is fluid and dependent on context. Each phase of a medical career, from
51 medical school through retirement, carries its own implications for what a physician should

1 know and be able to do to practice safely and to maintain effective relationships with patients
2 and with colleagues. Physicians at all stages of their professional lives need to be able to
3 recognize when they are and when they are not able to provide appropriate care for the patient
4 in front of them or the patients in their practice as a whole.

5
6 To fulfill the ethical responsibility of competence, individual physicians and physicians in
7 training should strive to:

8 (a) Cultivate continuous self-awareness and self-observation.

9 (b) Recognize that different points of transition in professional life can make different
10 demands on competence.

11 (c) Take advantage of well-designed tools for self-assessment appropriate to their practice
12 settings and patient populations.

13 (d) Seek feedback from peers and others.

14 (e) Be attentive to environmental and other factors that may compromise their ability to bring
15 appropriate skills to the care of individual patients and act in the patient's best interest.

16 (f) Maintain their own health, in collaboration with a personal physician, in keeping with
17 ethics guidance on physician health and wellness.

18 (g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to
19 practice safely is compromised by impairment, in keeping with ethics guidance on
20 physician responsibilities to impaired colleagues.

21
22 Medicine as a profession should continue to refine mechanisms for assessing knowledge and
23 skill and should develop meaningful opportunities for physicians and physicians in training to
24 hone their ability to be self-reflective and attentive in the moment.

25
26 (New HOD/CEJA Policy)

27
28 Fiscal Note: Less than \$500.

REFERENCES

1. *American Medical Association Code of Medical Ethics*. Principle I. Available at <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Accessed August 20, 2016.
2. *American Medical Association Code of Medical Ethics*. Opinion 11.2.1, Professionalism in health care systems. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
3. *American Medical Association Code of Medical Ethics*. Opinion 1.2.3, Consultation, referral and second opinions. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
4. *American Medical Association Code of Medical Ethics*. Opinion 1.1.6, Quality. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
5. Gordon MJ. A review of the validity and accuracy of self-assessments in health professions training. *Acad Med*. 1991;66:762–769.
6. *American Medical Association Code of Medical Ethics*. Principle II. Available at <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Accessed August 20, 2016.
7. *American Medical Association Code of Medical Ethics*. Opinion 9.4.2, Reporting incompetent or unethical behavior by colleagues. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
8. *American Medical Association Code of Medical Ethics*. Opinion 9.4.3, Discipline and medicine. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
9. *American Medical Association Code of Medical Ethics*. Opinion 8.6, Promoting patient safety. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
10. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226–235.
11. Epstein RM, Siegel DJ, Silberman J. Self-monitoring in clinical practice: a challenge for medical educators. *J Contin Educ Health Professions*. 2008;28(1):5–13.
12. Colthart I, Bagnall G, Evans A, et al. The effectiveness of self-assessment on the identification of learner needs, learner activity, and impact on clinical practice: BEME Guide no. 10. *Medical Teacher*. 2008;30:124–145.
13. DA, Mazmanian PE, Fordis M, et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA*. 2006;296:1094–1102.
14. Whitehouse A, Hassell A, Bullock A, et al. 360 degree assessment (multisource feedback) of UK trainee doctors: field testing of team assessment behaviors (TAB). *Medical Teacher*. 2007;29:171–178.
15. O'Sullivan P, Greene C. Portfolios: possibilities for addressing emergency medicine resident competencies. *Acad Emerg Med*. 2002;9(11):1305–1309.
16. Leigh IW, Smith IL, Bebeau M, et al. Competency assessment models. *Professional Psychology: Research and Practice*. 2007;38(5):463–473.
17. Lipsett PA, Harris I, Downing S. Resident self-other assessor agreement: influence of assessor, competency, and performance level. *Arch Surg*. 2011;146(8):901–906.
18. Svirko E, Lambert T, Goldacre MJ. Gender, ethnicity and graduate status, and junior doctors' self-reported preparedness for clinical practice: national questionnaire surveys. *J Royal Society Med*. 2014;107(2):66–74.
19. Dunning D. Strangers to ourselves? *The Psychologist*. 2006;19(10):600–603.
20. Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: how the desire for feedback and reticence to collect and use it can conflict. *Acad Med*. 2011;86(9):1120–1127.
21. Sargeant J, Mann K, Ferrier S. Exploring family physicians' reactions to multisource feedback: perceptions of credibility and usefulness. *Medical Education*. 2005;39:497–504.
22. Jackson JL, Kay C, Jackson WC, Frank M. The quality of written feedback by attendings of internal medicine residents. *J Gen Intern Med*. 2015;30(7):973–978.
23. Sargeant J, Amson H, Chesluk B, et al. The processes and dimensions of informed self-assessment: a conceptual model. *Acad Med*. 2010;85:1212–1220.

24. Moulton CE, Regehr G, Mylopoulos M, MacRae HM. Slowing down when you should: a new model of expert judgment. *Acad Med.* 2007;82(10 Suppl):S109–S116.
25. Moulton C, Regehr G, Lingard L, et al. Slowing down to stay out of trouble in the operating room: remaining attentive in automaticity. *Acad Med.* 2010;85(10):1571–1577.
26. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. *Acad Emerg Med.* 2002;9(11):1184–1204.
27. Sklar DP. How do we think? can we learn to think? *Acad Med.* 2014;89:191–193.
28. Klein JG. Five pitfalls in decisions about diagnosis and prescribing. *BMJ.* 2005;330:781–784.
29. Croskerry P, Petrie DA, Reilly B, Tait G. Deciding about fast and slow decisions. *Acad Med.* 2014;89:197–200.
30. Kadar N. Peer review of medical practices: missed opportunities to learn. *AJOG.* 2014; Dec:596–601.
31. Cooper LA, Roter DL, Carson KA, et al. The association of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health.* 2012;102:979–987.
32. Eva KW, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. *Acad Med.* 2005;80(10 Suppl):S46–S54.
33. Eva KW, Regehr G. Knowing when to look it up: a new conception of self-assessment ability. *Acad Med.* 2007;82(10 Suppl): 581–584.
34. Rivera AJ, Karsh B-T. Interruptions and distractions in healthcare: review and reappraisal. *Qual Saf Health Care.* 2010;19(4):304–312.
35. Grundgeiger T, Sanderson P. Interruptions in health care: theoretical views. *Intl J Med Informatics.* 2009;78:293–307.
36. Monsell S. Task switching. *TRENDS in Cog Sciences.* 2003;7(3).
37. Relihan E, O'Brien V, O'Hara S, et al. The impact of a set of interventions to reduce interruptions and distractions to nurses during medication administration. *Qual Saf Health Care.* 2010; May 28.
38. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv in Health Sci Educ.* 2009;14:595–621.
39. Epstein RM. Mindful practice. *JAMA.* 1999;282(9):833–839.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-19

Subject: Amendment to E-1.2.2, "Disruptive Behavior by Patients"

Presented by: Kathryn L. Moseley, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy D-65.991, "Discrimination against Physicians by Patients," directs the American Medical
2 Association (AMA) to study "(1) the prevalence, reasons for, and impact of physician,
3 resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and
4 other health care systems' policies or procedures for handling patient bias; and (3) the legal,
5 ethical, and practical implications of accommodating or refusing such reassignment requests."
6

7 The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics
8 concerns in this area and offers guidance for physicians when they encounter patients who refuse or
9 demand care based on the physician's perceived personal, rather than professional, characteristics.
10

11 REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE 12

13 It is not known just how often patients discriminate against or sexually harass physicians (and other
14 health care personnel) as data are not systematically collected or publicly reported. However, a
15 growing number of studies and an expanding body of anecdotal reports suggest that such behavior
16 is pervasive in health U.S. care [e.g., 1-7]. In the words of one analyst discrimination by patients is
17 medicine's "open secret" [4].
18

19 A survey conducted jointly by Medscape and WebMD in 2017 found that 59% of respondents
20 overall heard an offensive remark from a patient about the physician's personal characteristic,
21 including comments about the physician's weight and political views in addition to comments
22 about age, ethnicity or national origin, gender, race, and sexual orientation [8]. Emergency
23 physicians were significantly more likely to report having experienced bias (83%) than primary
24 care physicians (62%) or specialists (59%). Among respondents, more African American (70%),
25 Asian (69%), and Hispanic (63%) physicians reported hearing biased comments compared to white
26 physicians (55%). The same survey found that male and female physicians experience bias
27 differently, notably in terms of the physician characteristics targeted. For example, female
28 respondents reported experiencing bias more often on the basis of their gender or age than male
29 physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced
30 bias based on their ethnicity or religion somewhat more often than their female colleagues (24%
31 versus 20% and 15% versus 8%, respectively).

*Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 A variety of factors can drive patient behavior that is disrespectful, derogatory, or prejudiced,
2 including mental illness or incapacity or individual life experience, as well as personal beliefs and
3 bias. Different drivers carry different implications for whether, or to what degree, patients can
4 reasonably be held responsible for their problematic behavior. It would not be appropriate to hold
5 patients responsible or blameworthy for statements or actions that are not the product of rational
6 thought in the moment [9]. Thus, physicians' first response to problematic behavior should to
7 explore the reasons underlying the behavior so that they can identify, appreciate, and address
8 potentially treatable conditions. Behavior that outright threatens the safety of health care personnel
9 or other patients calls for prompt action to de-escalate the situation or remove the threat [e.g., 10,
10 11].

11
12 Lingering systemic racism and health disparities in the United States shape the experience of both
13 patients and health care professionals, especially those from nondominant communities [1, 3, 12].
14 Against this background, patients' reasons for refusing care by a specific physician or requesting a
15 different physician cover a "spectrum of justifiability" [13].

16
17 Requests not to be treated by a specific physician may reflect fears or concerns about care that are
18 rooted in systemic discrimination against members of the patient's community or traumatic
19 experiences in a patient's personal history [4, 9, 13]. Requests *for* a physician concordant in
20 ethnicity, religion, or gender may reflect cultural preferences or traditions, for example, a Muslim
21 woman's preference to receive care from a female physician. Such requests may also reflect
22 patients' experience, or reasonable expectation, that they will be better understood by a physician
23 "like them." Evidence suggests that at least for some patients, racial/ethnic or cultural concordance
24 between patient and physician supports more effective communication, enhances satisfaction, and
25 may have clinical benefit [4]. In these situations, it is appropriate to respect patient concerns and
26 preferences, when doing so is clinically feasible.

27
28 Requests for an alternative physician based solely on prejudice against personal characteristics of
29 the physician, however, are not justifiable and need not—perhaps should not—be accommodated
30 [4, 9, 13]. Requests based on a physician's (actual or perceived) race/ethnicity, national origin,
31 creed, gender identity, sexual orientation, disability, or other personal characteristic are ethically
32 objectionable.

33
34 For physicians and health care institutions faced with patients' strongly held views about who
35 should provide care, then, a central task is distinguishing when a patient's stated preference rests on
36 ethically acceptable reasons and when it reflects unacceptable bias or prejudice. When, that is, will
37 accommodation serve important patient interests and when will it reinforce problematic stereotypes
38 and, in effect if not intent, condone bigotry [2, 9]?

39
40 **PROTECTING INTERESTS, MINIMIZING HARMS**

41
42 Patient refusals of care or demands for alternative caregivers challenge physicians, and the
43 institutions in which they work, to protect both the interests of patients and those of physicians. In
44 such situations, physicians' professional obligations to promote patient well-being, respect patients
45 as moral agents and autonomous decision makers, and fulfill the duty to treat without
46 discrimination come into tension in potentially novel ways. Nor do these responsibilities align with
47 physicians' own interests in upholding professional autonomy and themselves being free from
48 discrimination. There are potential harms to both parties whether the physician/institution
49 accommodates bigoted requests and removes the caregiver or requires patient and physician to
50 engage one another in a troubled relationship.

1 Physicians' fiduciary obligations are fundamental. Physicians are expected to promote patients'
2 interest and well-being without regard to individuals' personal characteristics or behavior, up to
3 and including providing care to individuals whose behavior may be morally repugnant [13, 14].
4 But whether continuing to provide care or allowing oneself to be withdrawn from a case better
5 fulfills that fiduciary obligation is only intelligible in the individual case. So too are interpretations
6 of how a physician is to respect the autonomy of a patient who asserts moral agency in the form of
7 prejudice, and what the duty to care entails when the recipient behaves in a way that, arguably, is
8 not morally worthy or acceptable. Reaching sound determinations in these matters cannot be done
9 by rote; instead, as one commentator observed, doing so calls for "nuanced ethical judgment" [13].
10

11 The American Medical Association *Code of Medical Ethics* enjoins physicians to provide
12 "competent medical care, with compassion and respect for human dignity and rights" [15]. It also
13 acknowledges that, except in emergencies, physicians shall be "free to choose whom to serve" [16].
14

15 The Code further delineates the conditions under which a physician may decline to accept a new
16 patient (or provide a specific service to an existing patient [17]. These include when the care
17 requested is outside the physician's competence or scope of practice; when the physician lacks the
18 resources to provide safe, competent, respectful care for the individual; and when meeting this
19 patient's medically needs seriously compromises the physician's ability to provide the care needed
20 by other patients. Importantly, guidance acknowledges that, except in emergencies, a physician
21 may decline to provide care when the patient "is abusive or threatens the physician, staff, or other
22 patients" [17]. At the same time, the *Code* provides that physicians may terminate a relationship
23 with a patient who "uses derogatory language or acts in a prejudicial manner *only if the patient will*
24 *not modify the behavior*," in which case the physician should arrange to transfer the patient's care
25 [emphasis added] [18].
26

27 One approach to determining the ethically appropriate response to prejudiced behavior by patients
28 is to explore the harms—to patients, to physicians and other health care professionals, and to health
29 care institutions and even the wider community—that can result from different possible responses.
30 Who, that is, is harmed by a given response, and in what way?
31

32 Thwarting the requests of seemingly bigoted patients for alternative caregivers exposes patients to
33 possible delays in care and poorer health outcomes, should they choose to leave the facility (with or
34 without assistance from the institution). If they do not, or cannot leave, patients are subjected to the
35 experience of receiving medical care from a physician against whom they are biased.
36 Distinguishing between a preference for a different physician and a demand for one is important in
37 thinking about the nature and degree of harm the patient may experience. A preference is "an
38 expression of an inclination that may be gratified or not"; a demand is "more of an ultimatum, in
39 which failure to meet its indicia may be met not only with disappointment but also anger and
40 resentment" [9]. Further, it is important to determine why the patient is making the
41 request/demand, which may have a clinical source, such as delirium, dementia, or psychosis [4,
42 13], that is outside the patient's control, as opposed to being a stance the patient has voluntarily
43 adopted. And as noted previously, requests/demands may also reflect life experiences that color a
44 patient's response to caregivers for which accommodation may be appropriate.
45

46 For physicians and other caregivers, acceding to bigoted demands can send powerful, but
47 unintended and potentially hurtful messages—that minority or female physicians are "not as good"
48 as white male physicians or that patient satisfaction scores are more important to the institution
49 than promoting a safe and ethical working environment [1, 19]. Accommodating bigotry can make
50 institutions complicit in discrimination [19], in the process tacitly condoning or reinforcing an

1 institutional culture that routinely subjects minority physicians to “barrages of microaggressions
2 and biases” or expects them to serve as “race/ethnicity ambassadors” [1].
3
4 Institutions that fail to support staff in the face of prejudice convey that complying with patient
5 demands “is more important than respecting the dignity of both their staff members and the
6 majority of patients, who do not hold such repugnant views (or at least do not openly act on them)”
7 [9]. Institutions, some argue, “have a duty to present a moral face to their community by refusing to
8 honor bigoted or prejudicial requests or demands as a matter of course, up to and including
9 declining to care for such patients (except in emergency situations)” [9, cp. 20].
10

11 Regardless of how their institutions respond, for many minority health care professionals,
12 interactions with prejudiced patients are painful and degrading and contributed to moral distress
13 and burnout [4]. *Requiring* physicians to provide care when a patient has openly expressed bias is
14 not ethically tenable. As one physician described his own experience of ultimately declining to
15 work with a particular patient, “After years of feeling that my race was a nonissue, I was subjected
16 to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not
17 having thicker skin began to creep in, I decided that, on this occasion, my feelings would count”
18 [21]. Absent unique situations, institutions should allow physicians to control the decision about
19 whether they will continue to provide care [19]. Some have argued that institutions have a
20 responsibility to monitor such encounters and their effects on an ongoing basis “with the goal of
21 supporting staff and improving the handling of these situations” [4].
22

23 Whether patient prejudice against physicians adversely affects quality of care has not been well
24 studied. One experimental study among family practice physicians in the Netherlands concluded
25 that “disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors”
26 [22]. A companion study attributed this to the fact that the “mental resources” devoted to dealing
27 with patient behavior interfered with “adequate processing of clinical findings” [23]. Evidence does
28 indicate that physician “burnout” can adversely affect patient outcomes [e.g., 24–26]. To the extent
29 that being the target of patient prejudice contributes to the emotional exhaustion, sense of
30 depersonalization, and sense of low personal accomplishment characteristic of burnout, it is
31 reasonable to expect biased behavior to be associated with lower quality of care, particularly if
32 targeted physicians feel they do not have the support of their colleagues or institutions when bias
33 occurs [1, 21, 27, 28].
34

35 LAW AND POLICY

36

37 Legally, at the federal level how a health care institution responds to prejudiced behavior by
38 patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act*
39 (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA).
40 When patients make requests based on the physician’s race, hospitals are in the position of having
41 to meet EMTALA requirements while respecting physicians’ employment rights [4]. Hospitals can
42 “inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful
43 speech,” but their ability “to remove physicians in response to race-based requests is
44 circumscribed” [4]. Although physicians have not sued under CRA [4], in a case that ultimately
45 settled, an African-American nurse in Michigan sued her employer when she was barred from
46 caring for a white baby at the request of the child’s father, a white supremacist [29].
47

48 At present, relatively few institutions have formal policy or procedures for dealing with incidents
49 of patient prejudice, although an increasing number broadly enjoin patients to behave in a
50 respectful manner under policies delineating patient rights and responsibilities and indicate that
51 misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto’s University

1 Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of
2 patients and health care personnel.

3
4 UHN's *Caregiver Preference Guidelines* focus on three key questions: whether the preference for
5 an alternative caregiver appears to discriminate against the health care professional on the basis of
6 race, ancestry or other characteristic as provided in the *Ontario Human Rights Code*; whether the
7 request is clinically feasible and/or indicated to a reasonable degree; and whether the caregiver
8 wishes to excuse themselves from caring for the patient [27]. Mayo's recently adopted policy
9 directs staff to step in when they observe behavior that is not in keeping with Mayo Clinic values;
10 address the behavior with the patient, focusing the conversation on Mayo's published values;
11 explain the institution's expectations and set boundaries with the individual; and report the incident
12 to supervisors and document it via a patient misconduct form [27].

13
14 RECOMMENDATION

15
16 In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that
17 Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; Opinion 1.2.2,
18 "Disruptive Behavior by Patients," be amended by addition and deletion as follows; and the
19 remainder of this report be filed:

20
21 The relationship between patients and physicians is based on trust and should serve to promote
22 patients' well-being while respecting ~~their~~ the dignity and rights of both patients and
23 physicians.

24
25 Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for
26 accommodation of personal preferences on the part of either physicians or patients can
27 undermine trust and compromise the integrity of the patient-physician relationship. It can make
28 members of targeted groups reluctant to seek or provide care, and create an environment that
29 strains relationships among patients, physicians, and the health care team.

30
31 Trust can be established and maintained only when there is mutual respect. Therefore, in their
32 interactions with patients, physicians should:

33
34 (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause
35 psychological harm to those ~~they target~~ who are targeted.

36
37 (b) Always treat patients with compassion and respect.

38
39 (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced
40 ways. Physicians should identify, appreciate, and address potentially treatable clinical
41 conditions or personal experiences that influence patient behavior. Regardless of cause,
42 when a patient's behavior threatens the safety of health care personnel or other patients,
43 steps should be taken to de-escalate or remove the threat.

44
45 (d) In general, decline to accommodate patient requests for an alternative physician when the
46 request is solely the product of prejudice against the physician's personal characteristics.

47
48 (e) Consider accommodating a patient's request for an alternative physician when the request
49 derives from the patient's adverse personal experience, doing so would promote effective
50 care, and another appropriately qualified physician is available to provide the needed care.

1 (f) In emergency situations, patients who persist in opposing treatment from the physician
2 assigned may be helped to seek care from other sources. When transfer is not feasible,
3 patients should be informed that care will be provided by appropriately qualified staff
4 independent of the patient's expressed preference.

5

6 (eg) Terminate the patient-physician relationship with a patient ~~who uses derogatory language~~
7 ~~or acts in a prejudiced manner~~ whose volitional behavior is disrespectful, derogatory, or
8 prejudiced only if the patient will not modify the conduct. In such cases, the physician
9 should arrange to transfer the patient's care when that is feasible.

10

11 Physicians, especially those in leadership roles, should encourage the institutions with which
12 they are affiliated to:

13

14 (h) Be mindful of the messages the institution conveys within and outside its walls by how it
15 responds to prejudiced behavior by patients.

16

17 (i) Promote a safe and respectful working environment and formally set clear expectations for
18 how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

19

20 (j) Clearly and openly support physicians, trainees, and facility personnel who experience
21 prejudiced behavior and discrimination by patients.

22

23 (k) Collect data regarding incidents of discrimination by patients and their effects on
24 physicians and facility personnel on an ongoing basis and seek to improve how incidents
25 are addressed to better meet the needs of patients, physicians, other facility personnel, and
26 the community.

27

28 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. *JAMA Network Open*. 2018;1(5):e182723.
2. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. *Acad. Med.* 2016;91:S64–S69.
3. Fnais N, Soobiah C, Hong Chen M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med.* 2014;89:817–827.
4. Paul-Emile K. Patients Racial Preferences and the Medical Culture of Accommodation. *UCLA Law Rev.* 2012;60:462–504.
5. Reddy S. How doctors deal with racist patients. *The Wall Street Journal*. <https://www.wsj.com/articles/how-doctors-deal-with-racist-patients-1516633710>. Published January 22, 2018. Accessed July 23, 2019.
6. Novick DR. Racist Patients Often Leave Doctors at a Loss. *Washington Post*. http://wapo.st/2inREoW?tid=ss_mail&utm_term=.778203357cdf. Published October 19, 2017. Accessed July 23, 2019.
7. Haelle T. Physician guidance for dealing with racist patients. *Medscape*. <https://www.medscape.org/viewarticle/859354>. Published March 17, 2016. Accessed July 23, 2019.
8. Cajigal S, Scudder L. Patient prejudice: when credentials aren't enough. *Medscape*. Published October 18, 2017. Accessed July 23, 2019.
9. Rosoff PM. Discriminatory demands by patients. *Hastings Center Report*. 2018;48(4):7–11.
10. Price O, Baker J. Key components of de-escalation techniques: a thematic synthesis. *Intl J Mental Health Nursing*. 2012;21:310–319.
11. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17–25.
12. Malat J, Hamilton MA. Preference for same-race health care providers and perception of interpersonal discrimination in health care. *J. Health Social Behavior*. 2006;47(June):173–187.
13. Reynolds KL, Cowden JD, Brosco JP, Lantos JD. When a family requests a white doctor. *Pediatrics*. 2015;136(2):381–386.
14. Lepora C, Danis M, Wertheimer A. No Exceptionalism Needed to Treat Terrorists. *AJOB*. 2009;9(10):53–54.
15. American Medical Association *Code of Medical Ethics*. Principle I. Available at. <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Published 2017. Accessed July 23, 2019.
16. American Medical Association *Code of Medical Ethics*. Principle VI. Available at. <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Published 2017. Accessed July 23, 2019.
17. American Medical Association *Code of Medical Ethics*. Opinion 1.1.2 Prospective patients. Available at <https://policysearch.ama-assn.org/policyfinder/detail/1.1.2?uri=%2FAMADoc%2FEthics.xml-E-1.1.2.xml>. Published 2017. Accessed July 23, 2019.
18. American Medical Association *Code of Medical Ethics*. Opinion 1.2.2. Disruptive behavior by patients. Available at <https://policysearch.ama-assn.org/policyfinder/detail/transfer%20patient?uri=%2FAMADoc%2FEthics.xml-E-1.2.2.xml>. Published 2017. Accessed July 23, 2019.
19. Anstey K, Wright L. Responding to discriminatory requests for a different healthcare provider. *Nursing Ethics*. 2013;1–11.

20. McCruden P. Dealing with racist patient requests: law, rights, and Catholic identity. *Health Care Ethics USA*. 2017;Summer:21–29.
21. Jain SH. The racist patient. *Ann. Intern Med*. 2013;158:632.
22. Schmidt HG, van Gog T, CE Schuit S, et al. Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? a randomised experiment. *BMJ Quality & Safety*. 2017;26:19–23.
23. Mamede S, Van Gog T, Schuit SCE, et al. Why patients' disruptive behaviours impair diagnostic reasoning: a randomised experiment. *BMJ Quality & Safety*. 2017;26:13–18.
24. Lu DW, Dresden S, McCloskey C, Branzetti J, Gisondi MA. Impact of burnout on self-reported patient care among emergency physicians. *West J Emerg Med*. 2015;16(7):996–1001.
25. Dewa CS, Loong D, Bonato S, Trojanowski L. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open*. 2017;7:e01514.
26. Halbesleben JRB, Rathert, C. Lining physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Management Review*. 2008;33(1):29–39.
27. Warsame RM, Hayes SN. Mayo Clinic's 5-step policy for responding to bias incidents. *AMA Journal of Ethics*. 2019;21(6):E521–529.
28. Okwerekwu JA. The patient called me 'colored girl'. the senior doctor training me said nothing. *Stat*. <https://www.statnews.com/2016/04/11/racism-medical-education/>. Published April 11, 2016. Accessed July 23, 2019.
29. Castillo M. Detroit nurse claims hospital barred African American staff from caring for white child. *CBS News*. <https://www.cbsnews.com/news/detroit-nurse-claims-hospital-barred-african-american-staff-from-caring-for-white-child/>. Published February 19, 2013.
30. Penn State Health. Patient Rights Policy. *Penn State Health*. <https://hmc.pennstatehealth.org/documents/11396232/11459793/Patient+Rights+Policy+PC-33-HAM/b4f54eb1-7183-43cb-a606-640be66a84c8>. Published May 2018. Accessed July 23, 2019.
31. Massachusetts General Hospital. Patient Rights and Responsibilities. *Massachusetts General Hospital*. <https://www.massgeneral.org/advocacy/rights/default.aspx>. Published 2019. Accessed July 23, 2019.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-19)

Introduced by: Medical Student Section

Subject: Support for the Use of Psychiatric Advance Directives

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Nearly 10 million US adults live with serious mental illness, defined as a mental
2 illness that “result[s] in serious functional impairment” and “interferes with one or more major life
3 activities”¹⁻²; and
4
5 Whereas, A survey of 213 patients who previously received coercive psychiatric treatment found
6 that they would like to engage in advance planning to determine their preferences for future care
7 during psychiatric crises³; and
8
9 Whereas, A psychiatric advance directive is a legal document written by a competent individual
10 with a mental illness, specifying their treatment preferences and/or granting their medical power
11 of attorney to a surrogate during a future psychiatric crisis that impairs the individual’s capacity⁴⁻⁶;
12 and
13
14 Whereas, A psychiatric advance directive differs from generic advance directives due to the
15 unique nature of psychiatric illness and treatment⁵⁻⁷; and
16
17 Whereas, While most states enable psychiatric advance directive creation under broader
18 advance directive statutes, only 25 states have legislation pertaining specifically to the use of
19 psychiatric advance directives⁴⁻⁶; and
20
21 Whereas, In Nevada and New Hampshire, while a patient may designate an agent to make
22 healthcare decisions for them should they become incompetent, they may only specify in writing
23 advance instructions on non-psychiatric life-sustaining care⁴⁻⁶; and
24
25 Whereas, The Patient Self-Determination Act of 1990 states that Medicare and Medicaid
26 patients should be advised on opportunities to specify treatment preferences prior to the loss of
27 decision-making capacity when possible⁸; and
28
29 Whereas, The Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality
30 Reporting Program Manual specifies that a “patient should be allowed the opportunity to appoint
31 a surrogate decision maker or complete non-psychiatric and psychiatric advance directives”⁹;
32 and
33
34 Whereas, The use of psychiatric advance directives can help improve patient autonomy,
35 treatment adherence, and the physician-patient relationship and reduce the need for coercive
36 interventions such as involuntary commitment, seclusion, restraints, police transport, and
37 involuntary medications¹⁰⁻¹²; and

1 Whereas, In the first 6 months following psychiatric advance directive completion, 6.5 percent of
2 patients experienced a coherence crisis intervention compared to 19.7 percent of non-
3 completers¹⁰; and
4
5 Whereas, Patients with serious mental illness who participated in a facilitated psychiatric
6 advance directive completion session were 1.57 times more likely to experience an increase in
7 working alliance between themselves and clinicians after 1 month compared to patients who did
8 not experience the session¹¹; and
9
10 Whereas, Psychiatric advance directive completers were 7.8 times more likely to be adherent to
11 their psychiatric mediation after 1 year compared to non-completers¹²; and
12
13 Whereas, In the largest study of psychiatric advance directive usage to date, in over 1,000
14 patients with mental illness, only 7 percent of respondents had completed a psychiatric AD or
15 designated a surrogate for future psychiatric crises, while 68 percent of respondents expressed
16 interest in completing one¹³; and
17
18 Whereas, A survey of over 400 psychiatrists and psychologists showed that only 37 percent of
19 respondents demonstrated sufficient legal knowledge regarding psychiatric advance
20 directives¹⁴; and
21
22 Whereas, The use of facilitated psychiatric advance directive, an intervention in which a
23 psychiatric advance directive is completed by a patient with the assistance of a trained
24 individual, can reduce most barriers to psychiatric advance directive completion^{10,15}; and
25
26 Whereas, Low usage of psychiatric advance directive has led several states and organizations
27 to take steps to increase awareness and utilization of psychiatric advance directives, such as
28 establishing psychiatric advance directive completion clinics¹⁶⁻¹⁹; and
29
30 Whereas, Existing AMA policy “encourage[es] the use of advance directives and health care
31 powers of attorney” (H-140.845, Encouraging the Use of Advance Directives and Health Care
32 Powers of Attorney), “educating physicians about advance care planning” (H-85.956, Educating
33 Physicians About Advance Care Planning), and “promotes awareness and understanding of”
34 advance care planning in the unique situation of pregnancy (H-85.952, Advance Directives
35 During Pregnancy); and
36
37 Whereas, Similar to pregnant women, individuals with serious mental illness constitute a special
38 population with unique considerations that warrants additional attention in the area of advance
39 directive usage³⁻⁶; therefore be it
40
41 RESOLVED, That our American Medical Association support efforts to increase awareness and
42 appropriate utilization of psychiatric advance directives. (New HOD Policy)

Fiscal note: Minimal - less than \$1,000

Received: 08/28/19

References:

1. Results from the 2015 National Survey on Drug Use and Health. US Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality. <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>. Published Sep 8, 2016. Accessed March 1st 2019.
2. Serious Mental Illness (SMI) Among US Adults. US National Institutes of Health (NIH) National Institute of Mental Health (NIMH). <https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml/index.shtml>. Published 2016. Accessed March 1st, 2019.
3. Krieger E, Moritz S, Weil R, Nagel M. Patients' attitudes towards and acceptance of coercion in psychiatry. *Psychiatry Res.* 2018;260:478-485.
4. About PADs. National Resource Center on Psychiatric Advance Directives (NRC-PAD). <https://www.nrc-pad.org>. Updated 2018. Accessed March 1st, 2019.
5. Frequently Asked Questions About Psychiatric Advance Directives. National Resource Center on Psychiatric Advance Directives (NRC-PAD). <https://www.nrc-pad.org/faqs>. Updated 2018. Accessed March 1st, 2019.
6. Psychiatric Advance Directives (PAD). National Alliance on Mental Illness (NAMI). [https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-\(PAD\)](https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD)). Updated 2019. Accessed March 1st, 2019.
7. Olsen DP. Ethically Relevant Differences in Advance Directives for Psychiatric and End-of-Life Care. *J Am Psychiatr Nurses Assoc.* 2016;22(1):52-59.
8. HR 5835 Omnibus Budget Reconciliation Act of 1990, Title IV, Section 4206. US Congress. <https://www.congress.gov/bill/101st-congress/house-bill/5835/text>. Published Nov 5, 1990.
9. Inpatient Psychiatric Facility Quality Reporting Program Manual. US Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS). https://www.qualityreportingcenter.com/wp-content/uploads/2017/12/IPF_ProgramManual_Version3.1_20171211_vFINAL508.pdf. Published Dec 2017. Accessed March 1st, 2019.
10. Swanson JW, Swartz MS, Elbogen EB, et al. Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions. *J Ment Health.* 2008;17(3):255-267.
11. Swanson JW, Swartz MS, Elbogen EB, et al. Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Serious Mental Illness. *Am J Psychiatry.* 2006;163:1943-1951.
12. Wilder CM, Elbogen EB, Moser LL, et al. Medication Preferences and Adherence Among Individuals with Severe Mental Illness and Psychiatric Advance Directives. *Psychiatr Serv.* 2010;61:380-385.
13. Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R. Psychiatric Advance Directives Among Public Mental Health Consumers in Five US Cities: Prevalence, Demand, and Correlates. *J Am Acad Psychiatr & Law.* 2006;34(1): 43-57.
14. Elbogen, EB, Swartz MS, Van Dorn R, Swanson JW, Kim M, Scheyett A. Clinical Decision Making and Views About Psychiatric Advance Directives. *Psychiatr Serv.* 2006;57(3):350-355.
15. Easter MM, Swanson JW, Robertson AG, Moser LL, Swartz MS. Facilitation of Psychiatric Advance Directives by Peers and Clinicians on Assertive Community Treatment Teams. *Psychiatry Serv.* 2017;68(7):717-723.
16. Kemp K, Zelle H, Bonnie RJ. Embedding Advance Directives in Routine Care for Persons with Serious Mental Illness: Implementation Challenges. *Psychiatr Serv.* 2015;66(1):10-14.
17. Zelle H, Kemp K, Bonnie RJ. Advance Directives for Mental Health Care: Innovation in Law, Policy, and Practice. *Psychiatry Serv.* 2015;66(1):7-9.
18. Olsen DP. Increasing the Use of Psychiatric Advance Directives. *Nurs Ethics.* 2017;24(3):265-267.
19. Psychiatric Advance Directives (PAD) Project. The University of Texas at Austin School of Law. <https://law.utexas.edu/probono/opportunities/psychiatric-advanced-directives-pad-project>. Published Sep 2017. Accessed March 1st, 2019.

RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to

encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Educating Physicians About Advance Care Planning H-85.956

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17

Advance Directives During Pregnancy H-85.952

1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.

Citation: (BOT Rep. 9, I-15)

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.

Citation: (Res. 116, A-12; Reaffirmation A-15)

E-5.1 Advance Care Planning

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often

thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients' concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients' own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient's individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

- (a) Regularly encourage all patients, regardless of age or health status, to:
 - (i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);
 - (ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;
 - (iii) make their views known to their designated surrogate and to (other) family members or intimates.
- (b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.
- (c) Explain how advance directives, as written articulations of patients' preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate's responsibilities in decision making. Involve the patient's surrogate in this conversation whenever possible.
- (d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.
- (e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.

Issued: 2016

E-5.2 Advance Directives

Respect for autonomy and fidelity to the patient are widely acknowledged as core values in the professional ethics of medicine. For patients who lack decision-making capacity, these values are fulfilled through third-party decision making and the use of advance directives. Advance directives also support continuity of care for patients when they transition across care settings, physicians, or health care teams.

Advance directives, whether oral or written, advisory or a formal statutory document, are tools that give patients of all ages and health status the opportunity to express their values, goals for care, and treatment preferences to guide future decisions about health care. Advance directives also allow patients to identify whom they want to make decisions on their behalf when they cannot do so themselves. They enable physicians and surrogates to make good-faith efforts to respect the patient's goals and implement the patient's preferences when the patient does not have decision-making capacity.

An advance directive never takes precedence over the contemporaneous wishes of a patient who has decision-making capacity.

In emergency situations when a patient is not able to participate in treatment decisions and there is no surrogate or advance directive available to guide decisions, physicians should provide medically appropriate interventions when urgently needed to meet the patient's immediate clinical needs. Interventions may be withdrawn at a later time in keeping with the patient's preferences when they become known and in accordance with ethics guidance for withdrawing treatment.

Before initiating or continuing treatment, including, but not limited to, life-sustaining interventions, the physician should:

- (a) Assess the patient's decision-making capacity in the current clinical circumstances.
- (b) Ascertain whether the patient has an advance directive and if so, whether it accurately reflects his/her current values and preferences. Determine whether the patient's current clinical circumstances meet relevant thresholds set out in the directive.
- (c) Ascertain whether the patient has named a health care proxy (e.g., orally or through a formal legal document). If the patient has not, ask who the patient would want to have make decisions should he or she become unable to do so.
- (d) Document the conversation, including the patient's goals for care, and specific preferences regarding interventions and surrogate decision maker, in the medical record; incorporate any written directives (as available) into the medical record to ensure they are accessible to the health care team.
- (e) When treatment decisions must be made by the patient's surrogate, help the surrogate understand how to carry out the patient's wishes in keeping with the advance directive (when available), including whether the directive applies in the patient's current clinical circumstances and what medically appropriate interventions are available to achieve the patient's goals for care. When conflicts arise between the advance directive and the wishes of the patient's surrogate, the attending physician should seek assistance from an ethics committee or other appropriate institutional resource.
- (f) When a patient who lacks decision-making capacity has no advance directive and there is no surrogate available and willing to make treatment decisions on the patient's behalf, or no surrogate can be identified, the attending physician should seek assistance from an ethics committee or other appropriate resource in ascertaining the patient's best interest.
- (g) Document physician orders to implement treatment decisions in the medical record, including both orders for specific, ongoing interventions (e.g., palliative interventions) and orders to forgo specific interventions (e.g., orders not to attempt resuscitation, not to intubate, not to provide antibiotics or dialysis).

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-19)

Introduced by: Medical Student Section

Subject: Addressing the Racial Pay Gap in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Civil Rights Act prohibits discrimination based on race, color, religion, sex, or
2 national origin¹; and

3
4 Whereas, The racial wage gap persists across the labor market in the United States, meaning
5 that people of color earn less than their white counterparts in the same professions, conducting
6 the same work, with the same education and experience²; and

7
8 Whereas, The Bureau of Labor Statistics reports that in 1979 black men earned 80% of what
9 white men earned, whereas in 2016 black men earned 70% of what white men earn, suggesting
10 a worsening of the racial pay gap³; and

11
12 Whereas, The American College of Physicians has shown that after controlling for age, sex,
13 race, hours worked, and state of residence, Black physicians made \$194,444 annually,
14 compared to \$228,585 for White physicians – a difference of \$34,141⁴; and

15
16 Whereas, Black male physicians earn substantially less than white male physicians after
17 adjustment for physician specialty practice characteristics, age, and hours worked; and black
18 female physicians earn even less than their black male counterpart with adjustments accounting
19 for characteristics of physician and practice⁵; and

20
21 Whereas, White female physicians made 19 percent and Black female physicians made 29
22 percent less than their white male counterparts after controlling for hours worked, years of
23 practice, practice ownership status, board certification status, IMG status, type of degree,
24 demographics of practice, and proportion of Medicare and Medicaid patients⁵; and

25
26 Whereas, Black male physicians are more likely to work in primary care and to treat Medicaid
27 patients compared with white male physicians, adjustment for these and other practice
28 characteristics, does not eliminate, or even significantly reduce, the estimated differences in
29 earnings⁵; and

30
31 Whereas, A study of 128 academic medical centers found that Black or Hispanic faculty
32 constituted only 5% of new academic hires and had significantly longer promotion timelines
33 when compared to their white counterparts, after factors such as gender, tenure status, degree,
34 and NIH award status were adjusted for. Underrepresented minority (URM) faculty were still
35 less likely to be promoted at all levels⁶; therefore be it

1 RESOLVED, That our American Medical Association support measures of racial pay awareness
2 and the specific challenges that minority physicians face in regards to equal pay financial
3 attainment (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA support efforts to increase the transparency and accountability of
6 physician earnings through establishing transparency measures, in which physicians can
7 access information including but not limited to the salaries and race of medical physicians. (New
8 HOD Policy)

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

Received: 08/28/19

References:

1. Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241 (1964)
2. Treadwell HM. Wages and Women in Health Care: The Race and Gender Gap. *Am J Public Health*. 2019;109(2):208–209. doi:10.2105/AJPH.2018.304866
3. Bureau of Labor Statistics <https://www.bls.gov/opub/mlr/2017/beyond-bls/the-unexplainable-growing-black-white-wage-gap.htm>
4. Grisham, Sarah. "MedscapePhysicianCompensationReport2017." Medscape. April 5, 2017. Accessed August 23, 2017. <http://www.medscape.com/slideshow/compensation-2017-overview-6008547#1>
5. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ*. 2016;353:i2923. [Differences in incomes of physicians in the United States by race and sex: observational study <https://www.bmjjournals.org/content/353/bmji2923>]
6. Nunez-smith M, Ciarleglio MM, Sandoval-schaefer T, et al. Institutional variation in the promotion of racial/ethnic minority faculty at US medical schools. *Am J Public Health*. 2012;102(5):852-8.

RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

1. 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.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
- (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
- (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
- (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
- (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
- (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
- (8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
- (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-19)

Introduced by: Medical Student Section

Subject: Support Expansion of Good Samaritan Laws

Referred to: Reference Committee B

1 Whereas, In 2016, drug overdoses killed 63,632 Americans, the leading cause of preventable
2 death in the USA¹⁻³; and

4 Whereas, Opioid overdose can be effectively reversed using the opioid antagonist naloxone^{4,5};
5 and

7 Whereas, Between 21-68% of overdose bystanders call 911, but many delay or refrain from
8 calling 911 altogether often due to fear of arrest^{6,7}; and

10 Whereas, 46 states have passed some form of a "Good Samaritan Law" (GSL) as endorsed by
11 our AMA (D-95.977) to provide limited immunity from drug-related offenses to people who seek
12 medical assistance in the event of an overdose⁸; and

14 Whereas, Many people who use drugs are not aware these laws exist, one study found that
15 two-thirds of those surveyed were unaware of GSLs⁶; and

17 Whereas, A study in New York found that bystanders with a correct understanding of GSLs
18 were three times more likely to call 911 in the event of an overdose than those who had
19 incorrect knowledge about GSLs⁹; and

21 Whereas, GSLs provide variable legal protection by state, which may confer protection against
22 prosecution for specific crimes such as the possession of illicit/controlled substances,
23 paraphernalia, and/or parole/pretrial/probation violations^{6,10,11}; and

25 Whereas, A drug-induced homicide is defined as a crime in which a person delivered or
26 provided drugs to another person that resulted in their death¹²; and

28 Whereas, GSLs do not provide protections for drug-induced homicide^{7,13}; and

30 Whereas, Only Vermont and Delaware have specific laws that provide immunity for drug-
31 induced homicide if a person seeks medical assistance¹⁰; and

33 Whereas, Some states have enacted "911 Medical Amnesty Laws" to protect individuals from
34 arrest, prosecution or conviction of certain drug offenses if the evidence results from seeking
35 medical assistance for someone thought to be suffering from a drug overdose¹⁴; and

37 Whereas, The enactment of aforementioned medical amnesty policies in cases of underage
38 drinking have been shown to not increase consumption¹⁵; and

1 Whereas, As of 2016, 40 states had implemented medical amnesty laws protecting minors in
2 alcohol related emergencies¹⁶; and
3
4 Whereas, Implementation of Medical Amnesty Protocols (MAP) did not result in increased
5 drinking, overall consumption, or the incidence of physiological consequences¹⁷; and
6
7 Whereas, After the creation of MAP, Cornell students showed an increased willingness to seek
8 help for alcohol related emergencies, and there was a 61% decrease in the students who cited
9 fear of getting in trouble as the reason they did not call for help¹⁵; and
10
11 Whereas, The number of prosecutions of drug-induced homicide across the country has
12 increased over 300% since 2011, with the Midwest accounting for a large portion of this
13 increase; family members, friends, and partners are the frequent victims of these
14 prosecutions^{10,18-20}; and
15
16 Whereas, Increases in drug-induced homicide prosecutions are correlated with increases in
17 fatal overdose rates and studies suggest this may be due to increased fear of calling for
18 help^{7,10,18}; and
19
20 Whereas, Research suggests that a lack of Good Samaritan laws can lead to conditions in
21 which there are higher opioid-related deaths and decreased medical interventions--representing
22 a real public health concern²¹; therefore be it
23
24 RESOLVED, That our American Medical Association amend Policy D-95.977 by addition
25 and deletion to read as follows:
26
27 **911 Good Samaritan Laws, D-95.977**
28 Our AMA: (1) will support and endorse policies and legislation that provide
29 protections for callers or witnesses seeking medical help for overdose victims; and
30 (2) will promote 911 Good Samaritan policies through legislative or regulatory
31 advocacy at the local, state, and national level; and (3) will work with the relevant
32 organizations and state societies to raise awareness about the existence and scope
33 of Good Samaritan Laws. (Modify Current HOD Policy)

Fiscal note: Minimal - less than \$1,000

Received: 08/28/19

References:

1. U.S. Department of Health and Human Services. *U.S. Drug Overdose Deaths Continue to Rise; Increase Fueled by Synthetic Opioids.*; 2018. <https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html>. Accessed January 6, 2019.
2. Ahmad FB, Rossen LM, Spencer MR, Warner M, Sutton P. *Provisional Drug Overdose Death Counts.*; 2018. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. Accessed January 6, 2019.
3. Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *MMWR Morb Mortal Wkly Rep.* 2016;65(5051):1445-1452. doi:10.15585/mmwr.mm655051e1
4. Giglio RE, Li G, Dimaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. 2011. doi:10.1186/s40621-015-0041-8
5. Boyer EW. Management of Opioid Analgesic Overdose. *N Engl J Med.* 2012;367(2):146-155. doi:10.1056/NEJMra1202561
6. Latimore AD, Bergstein RS. "Caught with a body" yet protected by law? Calling 911 for opioid overdose in the context of the Good Samaritan Law. *Int J Drug Policy.* 2017;50:82-89. doi:10.1016/j.drugpo.2017.09.010
7. McLean K. Good Samaritans vs. predatory peddlers: problematizing the war on overdose in the United States. *J Crime Justice.* 2018;41(1):1-13. doi:10.1080/0735648X.2016.1215932
8. Corey D. *Overview of Naloxone Access and Good Samaritan Laws.*; 2017. https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf. Accessed January 6, 2019.
9. Jakubowski A, Kunins H V., Huxley-Reicher Z, Siegler A. Knowledge of the 911 Good Samaritan Law and 911-calling behavior of overdose witnesses. *Subst Abus.* 2018;39(2):233-238. doi:10.1080/08897077.2017.1387213

10. Drug Policy Alliance. *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane Background: Overdose Crisis and Response Increasing Rates of Opioid Overdose Response to Opioid Overdose Crisis.*; 2017. http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf. Accessed September 1, 2018.
11. Knopf A. Good Samaritan laws undercut by prosecutions. *Alcohol Drug Abus Wkly*. 2016;28(3):3-5. doi:10.1002/adaw.30440
12. US Food and Drug Administration. *21 U.S. Code Subchapter I - Control and Enforcement*. <https://www.law.cornell.edu/uscode/text/21/chapter-13/subchapter-I>. Accessed January 6, 2019.
13. Tobin KE, Davey MA, Latkin CA. Calling emergency medical services during drug overdose: an examination of individual, social and setting correlates. *Addiction*. 2005;100(3):397-404. doi:10.1111/j.1360-0443.2005.00975.x
14. Representatives Cooper of the 43rd, Oliver of the 82nd, Rutledge of the 109th W of, the 166th B of the 4th. *Georgia's 911 Medical Amnesty Law - HB 965/AP*. Georgia House Bill; 2014:1-10. <http://www.legis.ga.gov/Legislation/20132014/144369.pdf>. Accessed February 3, 2019.
15. Lewis DK, Marchell TC. Safety first: A medical amnesty approach to alcohol poisoning at a U.S. university. *Int J Drug Policy*. 2006. doi:10.1016/j.drugpo.2006.02.007
16. The Medical Amnesty Initiative. Medical Amnesty. States with Medical Amnesty . <https://www.medicalamnesty.org/>. Published 2016. Accessed March 28, 2019.
17. Haas AL, Wickham RE, McKenna K, Morimoto E, Brown LM. Evaluating the Effectiveness of a Medical Amnesty Policy Change on College Students' Alcohol Consumption, Physiological Consequences, and Helping Behaviors. *J Stud Alcohol Drugs*. 2018;79(4):523-531. <http://www.ncbi.nlm.nih.gov/pubmed/30079866>. Accessed March 28, 2019.
18. Beletsky L. America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis. *SSRN Electron J*. May 2018. doi:10.2139/ssrn.3185180
19. Goldensohn R. *They Shared Drugs. Someone Died. Does That Make Them Killers?*; 2018. <https://www.nytimes.com/2018/05/25/us/drug-overdose-prosecution-crime.html>. Accessed January 6, 2019.
20. Rothberg RL, Stith K. The Opioid Crisis and Federal Criminal Prosecution. *J Law, Med Ethics*. 2018;46(2):292-313. doi:10.1177/1073110518782936
21. Rees DI, Sabia JJ, Argys LM, Latshaw J, Dave D. *With a Little Help from My Friends: The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths.*; 2017. <http://www.nber.org/papers/w23171>. Accessed January 6, 2019.

RELEVANT AMA POLICY

911 Good Samaritan Laws D-95.977

Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

Citation: (Res. 225, A-14)

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18

Harm Reduction Through Addiction Treatment H-95.956

The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the

inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy.

Citation: (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)

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.

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19

Support for Medical Amnesty Policies for Underage Alcohol Intoxication H-30.938

Our AMA supports efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others.

Citation: (Res. 202, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-19)

Introduced by: International Medical Graduates Section
Minority Affairs Section

Subject: Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians

Referred to: Reference Committee B

1 Whereas, One in four of the practicing physician workforce in the United States of America are
2 trained at an international medical school¹; and
3
4 Whereas, 41% of the international medical graduates (IMG) serve in the primary care
5 disciplines, as defined by the Association of American Medical Colleges (AAMC), including
6 internal medicine, family medicine, pediatrics and geriatrics²; and
7
8 Whereas, An American Medical Association and American Osteopathic Association database
9 study showed that the IMGs are more likely to serve in the rural persistent poverty areas in
10 primary care, compared to their U.S. counterparts and DOs³; and
11
12 Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care
13 physicians has been projected by a recent American Association of Medical Colleges report⁴;
14 and
15
16 Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one
17 third of the currently active physicians will be older than 65 in the next decade⁴; and
18
19 Whereas, If people in the underserved and rural areas and people without insurance would use
20 healthcare the same way as the people with insurance and the people in the metropolitan areas;
21 an additional 31,600 physicians were needed in 2016⁴; and
22
23 Whereas, Critical access hospitals in underserved areas continue to face a crisis due to
24 uncompensated care and limited retention of physicians; and
25
26 Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill,
27 of a lower socioeconomic background and uninsured⁵, resulting in significant disparities in rural
28 and urban health care status and life expectancy⁶; and
29
30 Whereas, The overall number of U.S. medical graduates choosing careers as general internist
31 has declined over many years and retention of general practice physicians remained a
32 persistent challenge in improving health care access in these areas⁷; and

1 Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway
2 for IMGs to serve in the federally designated health professional shortage area (HPSA) with a
3 majority of Medicare/Medicaid and uninsured population for a longer duration, an increased
4 number of IMGs to be available in each state to serve in these areas and have incentives to
5 serve and settle in these areas; therefore be it
6
7 RESOLVED, That our American Medical Association support efforts to retain and incentivize
8 international medical graduates serving in federally designated health professional shortage
9 areas after the current allocated period. (Directive to Take Action).

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

Received: 10/01/19

1. About ECFMG: overview. Educational Commission for Foreign Medical Graduates website. <http://www.ecfmg.org/about/index.html>. Accessed February 8, 2015.
2. Center for Workforce Studies. *2013 State Physician Workforce Data Book*. Washington, DC: American Association of Medical Colleges; 2013. <https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf>. Accessed August 14, 2019.
3. Fordyce MA, Doescher MP, Chen FM, Hart LG. Osteopathic physicians and international medical graduates in the rural primary care physician workforce. *Fam Med*. 2012;44(6):396-403.
4. Dall T, Reynolds R, Jones K, Chakrabarti R, Lacobuci W. Center for Workforce Studies. *The Complexities of Physician Supply and Demand: Projections from 2017-2032*. Washington, DC: Association of American Medical Colleges; 2019. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed August 14, 2019.
5. Rosenblatt RA, Chen FM, Lishner DM, et al.. The future of family medicine and implications for rural primary care physician supply. University of Washington, School of Medicine 2010; Available at: http://depts.washington.edu/uwrhc/uploads/RHRC_FR125_Rosenblatt.pdf. Accessed August 14, 2019
6. Singh GK, Siahpush M. Widening rural-urban disparities in life expectancy, U.S., 1969-2009. *Am J Prev Med*. 2014
7. Whitcomb ME. The challenge of providing doctors for rural America. *Acad Med*. 2005;80:715-716

RELEVANT AMA POLICY

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health

centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians. Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these

efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these

and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-19)

Introduced by: American Society of Transplant Surgeons

Subject: Federal Government Regulation and Promoting Patient Access to Kidney Transplantation

Referred to: Reference Committee B

1 Whereas, Kidney transplantation is the best and most cost-effective treatment for many patients
2 with End Stage Renal Disease (ESRD); and
3
4 Whereas, Executive Order on Advancing American Kidney Health¹, issued on July 10, 2019,
5 seeks to increase patient choice through affordable ESRD therapy by encouraging higher value
6 care; and
7
8 Whereas, The Executive Order intent is to increase access to kidney transplants by modernizing
9 the organ recovery and transplantation systems and updating outmoded and counterproductive
10 regulations; and
11
12 Whereas, There exist comprehensive patient-oriented care models² designed with physician
13 input to promote access to transplantation; and
14
15 Whereas, Dialysis and transplant professional³⁻⁵ as well as patient-centered groups^{5,6} favor
16 physician-advised patient choice of kidney transplantation in ESRD treatment; and
17
18 Whereas, Payment models creating incentives for greater use of kidney transplants for ESRD
19 Medicare beneficiaries have been proposed; therefore be it
20
21 RESOLVED, That our American Medical Association engage US government regulatory and
22 professional organ transplant organizations to advance patient and physician-directed care for
23 End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA actively promote regulatory efforts to assure physician and patient
26 involvement in the design of any ESRD federal demonstration program (Directive to Take
27 Action); and be it further
28
29 RESOLVED, That our AMA actively advocate for legislative and regulatory efforts which create
30 incentives for dialysis providers, transplant centers, organ donors, and ESRD patients to
31 increase organ donation and improve access to kidney transplantation in the United States.
32 (Directive to Take Action).

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

Received: 10/02/19

References:

1. Executive Order on Advancing American Kidney Health, Issued on July 10, 2019
2. Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model: <https://innovation.cms.gov/initiatives/comprehensive-esrd-care/>
3. American Society of Transplant Surgeons: The ASTS-AST-AOPO-AAKP Joint Letter on Dialysis PATIENTS Demonstration Act of 2017: https://asts.org/docs/default-source/legislative/joint-letter-on-the-house-patients-act-december-1-2017.pdf?sfvrsn=94227ed3_2
4. DCI: Letter 2 November, 2017: http://asts.org/docs/default-source/test-document-library/dci-h-r-4143-letter-11-02-17.pdf?sfvrsn=83987fd3_2
5. American Association of Kidney Patients and the American Society of Nephrology: Letter 28 February, 2018: http://asts.org/docs/default-source/test-document-library/asn-aakletter-patientact-housesenate_2018-2-18.pdf?sfvrsn=82987fd3_4
6. The FAIR Foundation: www.FAIRfoundation.org : Policy adopted 28 January, 2018

RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962

Our AMA supports federal funding of organ transplants for Medicaid patients.

Citation: (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.

Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18;

UNOS Kidney Paired Donation Program H-370.960

Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.

Citation: (BOT Action in response to referred for decision Res. 2, A-13)

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963

1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ.
2. Our AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.

Citation: (Res. 104, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-19)

Introduced by: American Society of Transplant Surgeons

Subject: Federal Government Regulation and Promoting Renal Transplantation

Referred to: Reference Committee B

1 Whereas, Kidney transplantation is the best and most cost-effective treatment for many patients
2 with End Stage Renal Disease (ESRD); and

3
4 Whereas, The Executive Order on Advancing American Kidney Health¹, issued on July 10,
5 2019, seeks to increase patient choice through affordable ESRD therapy by encouraging higher
6 value care; and

7
8 Whereas, The Executive Order intent is to increase access to kidney transplants by modernizing
9 the organ recovery and transplantation systems while updating outmoded and
10 counterproductive regulations²; and

11
12 Whereas, Factors leading to deceased donor kidney discard in the US have been identified to
13 include donors who are older and or have co morbidities such as diabetes and hypertension³;
14 and

15
16 Whereas, Recent studies have shown that more than 2500 kidneys (>17% of those recovered
17 from deceased donors) were discarded in 2013 despite evidence that many of these kidneys
18 would provide a survival benefit to certain wait-listed patients⁴; and

19
20 Whereas, Studies have documented that excessive regulation and oversight have led transplant
21 centers to risk-aversion donor criteria which exclude kidneys which could benefit many
22 patients⁵⁻⁷; therefore be it

23
24 RESOLVED, That our American Medical Association actively advocate for US organ transplant
25 legislative and regulatory policies that would advance kidney transplantation by modifying or
26 eliminating arbitrary transplant center outcomes measures that currently discourage sound
27 clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many
28 patients. (Directive to Take Action)

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

Received: 10/02/19

References:

1. Executive Order on Advancing American Kidney Health, Issued on July 10, 2019
2. American Society of Transplant Surgeons: The ASTS Letter re: CMS-3346-P; Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CoPs) (Proposed Rule); RIN 0938-https://asts.org/docs/default-source/regulatory/asts-comments-on-pfs-qqp-2019-proposed-rule-september-10-2018.pdf?sfvrsn=14b040d3_
3. Mohan S, Chiles MC, Patzer RE, Pastan SO, Husain SA, Carpenter DJ, Dube GK, Crew RJ, Ratner LE, Cohen DJ. Factors leading to the discard of deceased donor kidneys in the United States. *Kidney Int.* 2018 Jul;94(1):187-198.
4. Reese PP, Harhay MN, Abt PL, Levine MH, Halpern SD. New Solutions to Reduce Discard of Kidneys Donated for Transplantation. *J Am Soc Nephrol.* 2016 Apr;27(4):973-80.
5. Stewart DE, Garcia VC, Rosendale JD, Klassen DK, Carrico BJ. Diagnosing the Decades-Long Rise in the Deceased Donor Kidney Discard Rate in the United States. *Transplantation.* 2017 Mar;101(3):575-587
6. Kadatz M, Gill JS. Compelling Evidence of the Need for Policy Change to Decrease Deceased Donor Kidney Discard in the United States: Waste Not Want Less. *Clin J Am Soc Nephrol.* 2018 Jan 6;13(1):13-15
7. Ouayogodé MH. Quality-based ratings in Medicare and trends in kidney transplantation. *Health Serv Res.* 2019 Feb;54(1):106-116.

RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962

Our AMA supports federal funding of organ transplants for Medicaid patients.

Citation: (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.

Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18;

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958

1. Our AMA supports 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. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will 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.

Citation: (Res. 7, I-15)

6.2.1 Guidelines for Organ Transplantation from Deceased Donors

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physicians 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:
 - (i) 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;
 - (ii) 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 recipients 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.

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.

Issued: 2016

Methods to Increase the US Organ Donor Pool H-370.959

In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues.

Citation: BOT Rep. 13, A-15; Reaffirmed in lieu of: Res. 002, I-16; Modified: CSAPH Rep. 02, I-17;

Organ Donation D-370.985

Our AMA will study potential models for increasing the United States organ donor pool.

Citation: Res. 1, A-14; Reaffirmed in lieu of Res. 5, I-14; Reaffirmed in lieu of: Res. 002, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-19)

Introduced by: Young Physicians Section

Subject: Ensuring Access to Safe and Quality Care for our Veterans

Referred to: Reference Committee C

1 Whereas, Studies have identified barriers related to physicians not employed by the Veterans
2 Administration (VA) and their ability to care for veterans as patients in addressing veterans'
3 status and addressing the military associated needs of this population^{1,2}; and

4
5 Whereas, Training of VA physicians require completion of educational modules for addressing
6 specific veteran needs³⁻⁶; and

7
8 Whereas, Recognition and treatment of these needs can be taught through the Talent
9 Management System 2.0 modules such as Veterans Health Administration Mandatory Training
10 for Trainees, Military Sexual Trauma, Traumatic Brain Injury, and Suicide Awareness Voices of
11 Education (SAVE)-Suicide³⁻⁶; and

12
13 Whereas, The availability of similar training resources could help physicians not employed by
14 the VA provide better care for veterans; therefore be it

15
16 RESOLVED, That our American Medical Association amend AMA Policy H-510.986, "Ensuring
17 Access to Care for our Veterans," by addition to read as follows:

18
19 Ensuring Access to Safe and Quality Care for our Veterans H-510.986

20 1. Our AMA encourages all physicians to participate, when needed, in the health care of
21 veterans.

22 2. Our AMA supports providing full health benefits to eligible United States Veterans to
23 ensure that they can access the Medical care they need outside the Veterans Administration
24 in a timely manner.

25 3. Our AMA will advocate strongly: a) that the President of the United States take immediate
26 action to provide timely access to health care for eligible veterans utilizing the healthcare
27 sector outside the Veterans Administration until the Veterans Administration can provide
28 health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long
29 term solution for timely access to entitled care for eligible veterans.

30 4. Our AMA recommends that in order to expedite access, state and local medical societies
31 create a registry of doctors offering to see our veterans and that the registry be made
32 available to the veterans in their community and the local Veterans Administration.

33 5. Our AMA supports access to similar clinical educational resources for all health care
34 professionals involved in the care of veterans as those provided by the U.S. Department of
35 Veterans Affairs to their employees with the goal of providing better care for all veterans.

36 6. Our AMA will strongly advocate that the Veterans Health Administration and Congress
37 develop and implement necessary resources, protocols, and accountability to ensure the
38 Veterans Health Administration recruits, hires and retains physicians and other health care
39 professionals to deliver the safe, effective and high-quality care that our veterans have been
40 promised and are owed. (Modify Current HOD Policy)

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

Received: 09/26/19

RELEVANT AMA POLICY:

Ensuring Access to Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18

References:

1. Bonnie M Vest, Jessica A Kulak, Gregory G Homish, Caring for veterans in U.S. civilian primary care: qualitative interviews with primary care providers, *Family Practice*, cmy078, <https://doi.org/10.1093/fampra/cmy078>
2. Vest BM, Kulak J, Hall VM, Homish GG. Addressing Patients' Veteran Status: Primary Care Providers' Knowledge, Comfort, and Educational Needs. *Fam Med*. 2018;50(6):455-459. <https://doi.org/10.22454/FamMed.2018.795504>.
3. Training for Trainees, Military Sexual Trauma, Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. <https://www.tms.va.gov>
4. Military Sexual Trauma, Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. Available at <https://www.tms.va.gov>.
5. Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. US Department of veterans Affairs Talent Management System 2.0. Available at <https://www.tms.va.gov>.
6. Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. Available at <https://www.tms.va.gov>.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-19

Subject: Established Patient Relationships and Telemedicine
(Resolution 215-I-18)

Presented by: W. Alan Harmon, MD, Chair

Referred to: Reference Committee J

1 At the 2018 Interim Meeting, the House of Delegates referred Resolution 215-I-18, "Extending the
2 Medical Home to Meet Families Wherever They Go," which was introduced by the American
3 Academy of Pediatrics. The Board of Trustees assigned this item to the Council on Medical
4 Service for a report back at the 2019 Interim Meeting. Resolution 215-I-18 asked that our
5 American Medical Association (AMA) "develop model legislation to permit primary care
6 physicians, who work in medical homes/primary care practices that satisfy the National Committee
7 for Quality Assurance Patient-Centered Medical Home Recognition Program guidelines, and who
8 have documented a face-to-face patient-care relationship, to provide telehealth services for the
9 patient when the patient travels to any of the fifty states."

10
11 This report provides an overview of state-based medical licensure and telemedicine; describes the
12 Interstate Medical Licensure Compact (the Compact); summarizes relevant AMA policy; and
13 makes recommendations.

14
15 **BACKGROUND**
16

17 Telemedicine is a key health care delivery innovation that has the potential to improve access to
18 care and reduce health care costs. The AMA advocates for policies that encourage the adoption of
19 telemedicine, while strongly supporting the current state-based medical licensure structure and the
20 ability of states to enforce their medical practice laws that are in place to protect patients.

21
22 Although technological developments have enabled the application of telemedicine across a range
23 of care settings, including patient-centered medical home practices, barriers to its widespread use
24 remain. The financial burden of implementing telemedicine was cited as one such barrier in a
25 recent study, which found that 15.4 percent of physicians worked in practices utilizing telemedicine
26 to interact with patients, and 11.2 percent worked in practices that used telemedicine for
27 interactions between physicians and health care professionals.¹

28
29 Referred Resolution 215-I-18 highlighted concerns historically raised by physicians that the state-
30 based licensure process has served as an additional barrier for physicians trying to expand
31 telemedicine practices. Unlike some countries that have national oversight of medical practice,
32 states are responsible for regulating the practice of medicine in the US. State authority to protect
33 the health of its citizens was granted in 1791 under the 10th Amendment of the US Constitution,
34 with formal licensing of physicians through state medical boards dating back to the 1800s.² The
35 primary goals of state medical boards are to protect patients, ensure quality health care, and foster
36 the professional practice of medicine. The prevailing standard for state medical licensure found in
37 the medical practice acts of each state affirms that the practice of medicine is determined to occur

1 where the patient is located, so that the full resources of the state are available for the protection of
2 that patient. Without such protection, a patient who receives services that fall short of the standard
3 of care would have limited recourse to seek redress and relief under the state's medical practice and
4 patient safety statutes and regulations.

5

6 Licensure requirements established by state medical boards vary with respect to telemedicine but,
7 according to the Federation of State Medical Boards (FSMB), 49 state boards—as well as the
8 medical boards of the District of Columbia, Puerto Rico, and the Virgin Islands—require
9 physicians practicing telemedicine to be licensed in the state in which the patient is located,³
10 consistent with AMA policy. Fourteen state medical boards issue a special purpose license,
11 telemedicine license or certificate, or license to practice medicine across state lines.⁴

12

13 Historically, the process of obtaining licenses to practice medicine in multiple states has been
14 burdensome and time-consuming for physicians, and some states formed interstate agreements to
15 practice medicine across state lines. The AMA has long supported solutions that make it easier for
16 physicians to obtain licenses to practice across multiple states, while preserving the ability of states
17 to protect patient health and oversee the care provided to patients within their borders. For many
18 years, the AMA urged policymakers to address the cost, time and paperwork burdens associated
19 with licensure, which were compounded when a physician sought licensure in more than one state.⁵
20 Accordingly, the AMA strongly supported development and implementation of the Compact as a
21 licensure solution that would make it easier and faster for physicians to obtain licenses to practice
22 in multiple states.⁶

23

24 *Interstate Medical Licensure Compact*

25

26 The Compact, developed over many years and officially launched in 2017, established a new
27 pathway to expedite the licensing of physicians already licensed to practice in one state, who seek
28 to practice medicine in one or more other states. This expedited process helps facilitate license
29 portability and allows physicians to practice medicine—including telemedicine—in a safe and
30 accountable manner that expands access to care without compromising patient protections. At the
31 time this report was prepared, the Compact was an agreement among the following 29 states, the
32 District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho,
33 Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana,
34 Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota,
35 Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.⁷

36

37 The Compact provides a licensing option under which qualified physicians seeking to practice in
38 multiple states are eligible for expedited licensure in all states participating in the Compact.
39 Licensing fees vary and remain the purview of each state's medical board. For a state to join the
40 Compact, the state legislature must enact authorizing legislation. A license obtained through the
41 expedited procedure provided for by the Compact provides the same licensing currently provided
42 for physicians by state medical boards—the only difference is that the process of obtaining a
43 license is significantly streamlined. Physicians can apply for licenses through the Compact on the
44 [Compact's website](#).

45

46 Importantly, the Compact creates another pathway for licensure and does not otherwise change a
47 state's medical practice act. Of priority to the AMA, facilitating expedited medical licensure
48 through the Compact ensures that states retain their roles in regulating the practice of medicine
49 and protecting patient welfare. The Compact adopts the prevailing standard that the practice of
50 medicine occurs where the patient is located at the time of the physician-patient encounter.

1 A physician practicing under a license facilitated by the Compact is thus bound to comply with the
2 statutes, rules and regulations of each Compact state wherein he/she chooses to practice medicine.
3 The Compact serves as a leading alternative to proposals to change the site of practice from where
4 the patient is located to where the physician is located for purposes of telemedicine, which would
5 usurp state authority to regulate the practice of medicine.

6
7 **AMA POLICY AND RESOURCES**

8
9 The recommendations contained in [Council on Medical Service Report 7-A-14](#) established Policy
10 H-480.946, which outlines safeguards and standards to support the appropriate coverage of and
11 payment for telemedicine services. In the report, the Council prioritized the need for AMA policy
12 to support future innovation in the use of telemedicine while ensuring patient safety, quality of care
13 and the privacy of patient information, as well as protecting the patient-physician relationship and
14 promoting improved care coordination and communication with medical homes.

15
16 A key safeguard included in Policy H-480.946 stipulates that physicians and other health
17 practitioners delivering telemedicine services must be licensed in the state where the patient
18 receives services, or be providing these services as otherwise authorized by that state's medical
19 board. In addition, the policy requires physicians and other health practitioners delivering
20 telemedicine services to abide by state licensure laws, state medical practice acts and other
21 requirements in the state where the patient receives services, and maintains that the delivery of
22 telemedicine services must be consistent with state scope of practice laws. The Council included
23 these safeguards in the recommendations of its report because the Council believed that the key
24 tenets in the delivery of in-person services hold true for the delivery of telemedicine services.
25 Policy H-480.946 also states that a valid patient-physician relationship must be established before
26 the provision of telemedicine services, through:

27
28 • A face-to-face examination, if a face-to-face encounter would otherwise be required in the
29 provision of the same service not delivered via telemedicine; or
30 • A consultation with another physician who has an ongoing patient-physician relationship
31 with the patient. The physician who has established a valid physician-patient relationship
32 must agree to supervise the patient's care; or
33 • Meeting standards of establishing a patient-physician relationship included as part of
34 evidence-based clinical practice guidelines on telemedicine developed by major medical
35 specialty societies, such as those of radiology and pathology.

36
37 Additionally, the policy maintains that prior to the delivery of any telemedicine service, physicians
38 need to verify that their medical liability insurance covers telemedicine services, including
39 telemedicine services provided across state lines, if applicable.

40
41 Long-standing AMA policy also maintains that medical boards of states and territories should
42 require a full and unrestricted license in that state for the practice of telemedicine, unless there are
43 other appropriate state-based licensing methods, with no differentiation by specialty, for physicians
44 who wish to practice telemedicine in that state or territory (Policy H-480.969). The policy also
45 states that this license category should adhere to the following principles:

46
47 • Application to situations where there is a telemedical transmission of individual patient
48 data from the patient's state that results in either; (i) provision of a written or otherwise
49 documented medical opinion used for diagnosis or treatment or; (ii) rendering of treatment
50 to a patient within the board's state;

1 • Exemption from such a licensure requirement for traditional informal physician-to-
2 physician consultations (“curbside consultations”) that are provided without expectation of
3 compensation;
4 • Exemption from such a licensure requirement for telemedicine practiced across state lines
5 in the event of an emergent or urgent circumstance, the definition of which for the purposes
6 of telemedicine should show substantial deference to the judgment of the attending and
7 consulting physicians as well as to the views of the patient; and
8 • Application requirements that are non-burdensome, issued in an expeditious manner, have
9 fees no higher than necessary to cover the reasonable costs of administering this process,
10 and that utilize principles of reciprocity with the licensure requirements of the state in
11 which the physician in question practices.

12 Policy D-480.999 opposes a single national federalized system of medical licensure. Policy
13 H-480.974 directs our AMA to work with the FSMB and state and territorial licensing boards to
14 develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969
15 states that our AMA will work with the FSMB to draft model state legislation to ensure that
16 telemedicine is appropriately defined in each state’s medical practice statutes and its regulation
17 falls under the jurisdiction of the state medical board. Policies H-275.978 and H-275.955 urge
18 licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed
19 physicians between states. Policy D-275.994 supports the Compact and directs the AMA to work
20 with interested medical associations, the FSMB and other interested stakeholders to ensure
21 expeditious adoption by the states of the Interstate Compact for Medical Licensure.
22

23 Policies H-480.974, H-480.968 and H-480.969 encourage national medical specialty societies to
24 develop appropriate and comprehensive practice parameters, standards and guidelines addressing
25 the clinical and technological aspects of telemedicine. Policy H-480.968 urges national private
26 accreditation organizations to require that medical care organizations that establish ongoing
27 arrangements for medical care delivery from remote sites require practitioners at those sites to meet
28 no less stringent credentialing standards and participate in quality review procedures that are at
29 least equivalent to those at the site of care delivery.
30

31 The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and
32 H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are
33 outlined in Policy H-160.937. This policy states that in all settings and circumstances, physician
34 supervision is required when nonphysician providers deliver services via telemedicine, and the
35 extent of supervision provided by the physician should conform to the applicable medical practice
36 act in the state where the patient receives services. Policy H-160.937 further states that
37 nonphysician providers who deliver services via telemedicine should do so according to the
38 applicable nonphysician practice acts in the state where the patient receives such services. Code of
39 Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through
40 telemedicine must uphold the standards of professionalism expected in in-person interactions,
41 follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law
42 governing the practice of telemedicine.
43

44 Consistent with AMA policy, AMA model state legislation ensures that, with certain exceptions
45 (eg, curbside consultations, volunteer emergency medical care), physicians and other health
46 practitioners practicing telemedicine are licensed in the state where the patient receives services or
47 are providing these services as otherwise authorized by that state’s medical board. A Continuing
48 Medical Education (CME) module, “[Adopting Telemedicine in Practice](#),” outlines steps physicians
49 should take before adopting telemedicine into practice and is available on the [AMA Ed Hub](#).
50

1 DISCUSSION

2

3 The Council appreciates the intent of referred Resolution 215-I-18 and understands the frustrations
4 of the authors. It is increasingly challenging for physician practices to compete with large
5 commercial entities that are contracting with payers to provide telemedicine services, including
6 primary care services. Commercial direct-to-consumer telemedicine enables patients to receive care
7 from their homes, offices or mobile devices; however, these encounters are provided outside of a
8 patient's medical home and can lead to fragmented care. Where there is an established patient
9 relationship, a physician should be able to use telemedicine to provide quality emergent or urgent
10 care for a patient's existing condition when that patient is traveling in another state.

11

12 The Council also discussed potential unintended consequences of the model legislation requested
13 via referred Resolution 215-I-18, which would create an exception for primary care physicians who
14 work in accredited patient-centered medical homes and would ultimately be very disruptive to
15 existing laws and regulations. The Council is concerned that such legislation, if implemented,
16 could result in national oversight of telemedicine provided across state lines, and that any national
17 oversight would be subject to influence by a variety of stakeholders including physicians, but also
18 commercial telemedicine providers and retail health clinics. Additionally, the Council believes it
19 would be difficult to limit the suggested exception to primary care physicians. It is possible that
20 direct-to-consumer telemedicine providers would be able to become medical homes, which could
21 in turn lead to other unintended consequences, such as the overprescribing of antibiotics.⁸

22

23 The Council believes that patient safety must remain a primary consideration during discussions of
24 proposals to enhance patient access to care through telemedicine, and that maintaining AMA policy
25 in support of state licensing boards having authority over medical services where patients are
26 located prioritizes patient protections. The Council notes that treating physicians not licensed by
27 the state where a patient is located may not receive public health department alerts, including
28 notice of local outbreaks such as measles or food borne illness.

29

30 The Council discussed the concerns raised by referred Resolution 215-I-18 and believes that the
31 Compact is a sensible and viable approach to facilitating multistate licensure without undermining
32 state jurisdiction over medical practice and patient health. The Council acknowledges that the
33 licensing option available under the Compact is not yet available to all physicians because not all
34 states have become members of the Compact. However, within two years after its official launch,
35 over half of all states joined the Compact and it was used by more than 3,000 physicians to secure
36 more than 5,400 medical licenses in Compact member states.⁹ The Council recognizes the
37 importance of persuading remaining states to join the Compact, which will ultimately facilitate
38 multistate licensure for most physicians who want it, and recommends that our AMA work with
39 state medical associations to encourage states that are not part of the Compact to consider joining it
40 as a means of enhancing patient access to and proper regulation of telemedicine services.

41

42 With respect to the travel considerations raised in referred Resolution 215-I-18, the Council
43 discussed the ability of physicians to provide telemedicine services to their patients while they are
44 traveling to another state and points to the practical exemptions from state licensure requirements
45 already encompassed in AMA policy—for emergent or urgent circumstances and “curbside
46 consultations.” Physicians who wish to provide telemedicine services to patients in a state where
47 they are not licensed are encouraged to direct inquiries to that state’s medical board.

48

49 Finally, the Council believes that state-based exceptions and carve-outs of not only AMA
50 telemedicine policy, but also state licensure laws, will further complicate oversight and regulation

1 and could potentially diminish the standards and patient safeguards that are centerpieces of AMA
2 policy. Accordingly, the Council also recommends reaffirming Policies H-480.946 and H-480.969.
3

4 **RECOMMENDATIONS**

5
6 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
7 215-A-18, and the remainder of the report be filed:
8

9 1. That our American Medical Association (AMA) work with state medical associations to
10 encourage states that are not part of the Interstate Medical Licensure Compact to consider
11 joining the Compact as a means of enhancing patient access to and proper regulation of
12 telemedicine services. (Directive to Take Action)
13

14 2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that
15 should be met for the coverage and payment of telemedicine, including that physicians and
16 other health practitioners delivering telemedicine services must be licensed in the state where
17 the patient receives services. (Reaffirm HOD Policy)
18

19 3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should
20 require a full and unrestricted license in that state for the practice of telemedicine, with no
21 differentiation by specialty, unless there are other appropriate state-based licensing methods,
22 and with exemptions for emergent or urgent circumstances and “curbside consultations.”
23 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Kane CK and Gillis K. The use of telemedicine by physicians: Still the exception rather than the rule. *Health Affairs* 37, No. 12 (December 2018). Available online at:

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05077>.

² Federation of State Medical Boards. Understanding Medical Regulation in the United States. Available online at: <https://www.fsmb.org/siteassets/education/pdf/best-module-text-intro-to-medical-regulation.pdf>.

³ Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. Jan. 23, 2018. Available online at: http://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.

⁴ Ibid.

⁵ American Medical Association. Statement for the Record to the Federal Trade Commission’s Economic Liberty Task Force. Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability. July 20, 2017. Available online at: https://searchlif.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-7-20-STATEMENT-FOR-THE-RECORD-Streamlining-Licensing-Across-State-Lines_final2.pdf.

⁶ American Medical Association. Statement for the Record to the Federal Trade Commission’s Economic Liberty Task Force. Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability. July 20, 2017. Available online at: https://searchlif.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-7-20-STATEMENT-FOR-THE-RECORD-Streamlining-Licensing-Across-State-Lines_final2.pdf.

⁷ The Interstate Medical Licensure Compact website: <https://imlcc.org/>.

⁸ Ray KN, Shi Z, Gidengil CA, Poon SJ, Uscher-Pines L and Mehrotra A. Antibiotic prescribing during pediatric direct-to-consumer telemedicine visits. *Pediatrics* 143, No. 5 (May 2019).

⁹ The Interstate Medical Licensure Compact. Press Release dated April 27, 2019.

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-19)
Mechanisms to Address High and Escalating Pharmaceutical Prices
(Reference Committee J)

EXECUTIVE SUMMARY

At the past several meetings of the House of Delegates, significant concerns have been raised regarding how high and increasing drug prices have impacted patients and physician practices. The Council on Medical Service spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to pharmaceutical costs and pricing, and concluded that additional policy is needed to respond to innovative proposals addressing pharmaceutical pricing that could potentially be included in future legislation and regulations, including those that call for the use of arbitration, leverage international price indices and averages to determine drug prices, or implement contingent exclusivity periods for pharmaceuticals.

The Council has long prioritized the importance of competition and transparency in the pharmaceutical marketplace, but recognizes that there are multiple situations in which payers have weakened bargaining power, due to lack of competition for some drugs. In addition, there is often limited recourse following an unjustifiable price hike of a prescription medication, leaving patients questioning whether they will be able to continue to afford their medication. As such, the Council recommends policies to promote reasonable pricing behavior in the pharmaceutical marketplace, as an alternative to price controls.

First, the Council recommends principles to guide the use of arbitration in determining the price of prescription drugs, which build upon existing policy in favor of drug price negotiation, and opposed to price controls. Arbitration should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases. Using arbitration will help rebalance the importance of prescription drug affordability with the need for innovation, as an alternative to the status quo, which allows unilateral price setting of drugs by manufacturers without regard to patient access and affordability. Importantly, arbitration provides an incentive for drug manufacturers and payers to arrive at a negotiated price.

The Council stresses that arbitration should be coupled with additional policy proposals that promote value and encourage competition within the pharmaceutical marketplace. The Council believes that incorporating a drug's value and cost-effectiveness as factors in determining its length of market exclusivity has the potential to promote increased competition for therapies that are priced too high in relation to their clinical effectiveness and overall value. As such, the Council recommends support for the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of a drug to its cost-effectiveness at its list price at the time of market introduction.

Finally, with the introduction of proposals that would use the average of a drug's price internationally to serve as an upper limit in drug price negotiations, set a drug's price in Medicare Part B or determine whether a drug's price is "excessive" to trigger additional interventions, the Council recommends safeguards to ensure that such international drug price averages are used in a way that upholds market-based principles and preserves patient access to necessary medications.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-19

Subject: Mechanisms to Address High and Escalating Pharmaceutical Prices

Presented by: W. Alan Harmon, MD, Chair

Referred to: Reference Committee J

1 At the past several meetings of the House of Delegates, significant concerns have been raised
2 regarding how high and increasing drug prices have impacted patients and physician practices. The
3 Council on Medical Service spent the past year reviewing the substantial body of American
4 Medical Association (AMA) policy pertaining to pharmaceutical costs and pricing, determining
5 whether additional policy was needed to guide future AMA advocacy efforts. In its review, the
6 Council concluded that additional AMA policy is needed to respond to innovative proposals
7 addressing pharmaceutical pricing that could potentially be included in future legislation and
8 regulations, including those that call for the use of arbitration, leverage international price indices
9 and averages to determine drug prices, or implement contingent exclusivity periods for
10 pharmaceuticals.

11
12 This report provides background on the impacts of high and escalating prescription drug prices and
13 costs; outlines emerging approaches to address pharmaceutical pricing; and presents policy
14 recommendations.

15
16 **THE IMPACTS OF HIGH AND ESCALATING PRESCRIPTION DRUG PRICES AND COSTS**
17

18 Retail prescription drugs account for 10 percent of total health spending,¹ with estimates suggesting
19 that spending on prescription drugs is closer to 15 percent of total health spending when other
20 factors, including the non-retail drug markets and gross profits of other stakeholders involved in
21 drug distribution, payment, and reimbursement are included.² Of significance, spending on
22 specialty drugs is approaching one-half of drug spending.³ The most recent National Health
23 Expenditure projections showed that retail prescription drug spending was estimated to have
24 increased by 3.3 percent to \$344.5 billion in 2018, with a 4.6 percent increase in spending expected
25 in 2019. Drivers behind the rate of growth in prescription drug spending include a higher number
26 of new drug introductions, increased utilization of prescription drugs, and an increase in drug price
27 growth. The projected annual growth in prescription drug spending is expected to average 6.1
28 percent from 2020 through 2027. Contributions to future growth in spending in the prescription
29 drug sector include increased prescription drug utilization resulting from employer and insurer
30 efforts to remove barriers associated with medications for chronic conditions; expected market
31 release of more expensive drugs for conditions including cancer, diabetes, and Alzheimer's
32 disease; the aging of the population; and modifications to pharmacotherapy guidelines.⁴

33
34 Approximately 5.8 billion prescriptions were dispensed in the US in 2018, 90 percent of which
35 were dispensed as generics. The retail price differentials between specialty, brand-name and
36 generic drugs are noteworthy. Examining the retail prices of drugs widely used by older
37 Americans, in 2017 the average annual retail price of therapy for specialty drugs was \$78,781,
38 dropping to \$6,798 for brand-name drugs, and \$365 for generics.⁵ Overall, the list price of the

1 average brand drug was \$657.08 for a 30-day prescription in 2018, a noteworthy increase from
2 \$364.92 in 2014. The average prices of brand-name drugs at pharmacies before coupons and
3 discounts are applied were \$229 lower than list prices in 2018 for a 30-day prescription.⁶ Average
4 generic pharmacy prices for a 30-day prescription were relatively stable from 2014 to 2018,
5 increasing to \$19.10 from \$18.50.⁷

6
7 Health plans, payers, employers, physicians and patients are facing the increasing financial burden
8 posed by prescription drugs, both brand and generic. In the Medicare program, between 2007 and
9 2017, Part D program spending has seen an annual growth rate of 5.6 percent, and amounted to
10 \$79.9 billion in 2017. Premiums paid by Part D enrollees for basic benefits (not including low-
11 income subsidy enrollees) amounted to \$14 billion in 2017, which has increased by 13 percent on
12 average annually since 2007. High-cost enrollees are a primary contributor to Part D spending
13 growth, with the associated spending growth for high-cost enrollees resulting from higher drug
14 prices.⁸ Under Medicare Part B, drug spending has increased on average by 9.6 percent annually
15 between 2009 and 2017, with the largest driver of this growth in spending being price growth – a
16 combination of increasing prices for existing drugs as well as the introduction of new high-cost
17 drugs in the market. In 2017, \$18 billion of total Part B spending was for drugs administered in
18 physician offices, approximately \$12.3 billion was for drugs administered in hospital outpatient
19 departments, and \$1.8 billion was for drugs provided by suppliers.⁹

20
21 Rising and high prescription drug prices are impacting Medicaid budgets and state budgets overall.
22 Under the Medicaid drug benefit, drug manufacturers pay rebates to states in return for Medicaid
23 reimbursement for their prescription drugs. Drug manufacturers are required to pay an additional
24 rebate amount if the average manufacturer price (AMP) for a drug rises faster than inflation. From
25 2014 to 2017, Medicaid outpatient prescription drug spending before rebates increased from \$45.9
26 billion to \$63.6 billion.¹⁰ The \$34.9 billion collected in rebates brought net Medicaid spending on
27 prescription drugs down significantly in fiscal year (FY) 2017. The proportion of spending geared
28 to brand-name versus generic drugs in Medicaid increased – from 76.6 percent in FY 2014 to 80.5
29 percent in FY 2017. This growth resulted from an increase in average spending per claim for brand
30 drugs – from \$294 per claim in FY 2014 to \$411 per claim in FY 2017. Of note, the share of
31 spending on specialty drugs has significantly increased in Medicaid – accounting for approximately
32 44 percent of spending in FY 2017.¹¹

33
34 Employer-sponsored health plans as well as health plans sold in the individual market have also
35 had to absorb the higher costs of prescription drugs, which often translate to higher premiums,
36 higher prescription drug cost-sharing, and additional prescription drug tiers to accommodate the
37 higher costs of specialty and certain generic drugs. In 2018, 88 percent of employees were enrolled
38 in plans with three, four or more cost-sharing tiers for prescription drugs.¹² This year, almost all
39 standalone Medicare Part D plans have a benefit design with five tiers for generic and brand-name
40 drugs and cost-sharing that deviates from the standard 25 percent coinsurance for all covered drugs
41 between the deductible and the initial coverage limit.¹³

42
43 The higher costs of prescription drugs are in part passed down to health plan enrollees, and impact
44 physician practices. Ultimately, prescription drug costs can impact the ability of physicians to place
45 their patients on the best treatment regimen, due to the regimen being unaffordable for the patient,
46 or being subject to coverage limitations and restrictions, as well as utilization management
47 requirements, by the patient's health plan. In the worst-case scenario, patients entirely forgo
48 necessary treatments involving drugs and biologics due to their high cost.

49
50 In 2018, overall out-of-pocket costs for prescription drugs reached \$61 billion, an increase from
51 \$56 billion in 2014. Across Medicare, Medicaid and commercial health plans, 8.8 percent of

1 patients pay more than \$500 per year out-of-pocket for prescriptions. Medicare beneficiaries have a
2 notably higher incidence rate of high out-of-pocket expenses for prescription drugs, with almost 20
3 percent paying more than \$500 out-of-pocket.¹⁴ Nonpreferred generic tiers in many cases have
4 higher copayments than patients have become accustomed to for generic medications. In addition,
5 plans with specialty drug cost-sharing tiers often require coinsurance amounts of 25 to 50 percent,
6 versus requiring a fixed copayment. Considering the costs of many specialty medications, patients
7 could quickly reach their deductibles and out-of-pocket maximums. The increased use and cost of
8 specialty drugs in Medicare could cause the number of Part D enrollees who reach the catastrophic
9 coverage threshold to grow substantially, resulting in increases in Medicare spending to plans for
10 reinsurance.

11

12 Increasing patient cost-sharing is associated with declines in medication adherence, which in turn
13 can lead to poorer health outcomes. Among those currently taking prescription drugs,
14 approximately a quarter of adults and seniors have reported difficulties in affording their
15 prescription drugs. Approximately 30 percent of all adults have reported not taking their
16 medications as prescribed at some point in the past year due to cost. Drilling down further, 19
17 percent of adults have not filled a prescription in the past year due to cost, 18 percent chose to take
18 an over-the-counter medication instead, and 12 percent cut pills in half or skipped doses. Of
19 significance, almost 10 percent of all adults reported that their condition worsened from not taking
20 their medication as prescribed.¹⁵

21

22 Notably, out-of-pocket costs for prescription drugs are linked to the rate at which patients newly
23 prescribed a drug either do not pick up their prescription or switch to another product. The rate at
24 which such patients, enrolled in either Medicare or a commercial health plan, abandon their
25 prescription increases significantly once out-of-pocket costs reach \$50. At this point, 31.2 percent
26 of commercially insured patients and 27.6 percent of Medicare patients abandon their
27 prescriptions.¹⁶

28

29 High prescription drug costs, and any declines in medication adherence that may result, can also
30 impact physicians participating in alternative payment models (APMs). For example, Part B drug
31 costs are included in calculations of APM financial risk, even though physicians cannot influence
32 or control drug prices. In addition, physicians in APMs can be affected if poor medication
33 adherence leads to complications or exacerbations that in turn lead to emergency department visits
34 and/or hospital admissions.

35

36 EMERGING APPROACHES TO ADDRESS HIGH AND ESCALATING DRUG PRICES

37

38 Escalating and increasingly unaffordable drug prices have caused the Administration, members of
39 Congress and policy experts to put forward innovative proposals to put downward pressure on
40 prices, or more closely tie a drug's price to its value. Whereas proposals that would allow for
41 binding arbitration and contingent exclusivity periods could build upon existing market-based
42 approaches to address pharmaceutical prices and costs, caution would have to be exercised in
43 implementing proposals that leverage international price indices, so as to not merely import
44 international price controls into the US.

45

46 *Utilizing Binding Arbitration*

47

48 An emerging policy option that has been put forward to address high and escalating drug prices is
49 using binding arbitration in the event of failed drug price negotiations in order to settle on the final
50 price of the drug. Supporters argue that binding arbitration has the potential to build upon the
negotiations that currently take place along the pharmaceutical supply chain that determine

1 coverage of and payment for prescription drugs. In the US, binding arbitration is currently used in
2 public-sector labor-management negotiations, and Major League Baseball uses the approach in the
3 event of failed negotiations for baseball players' salaries. While negotiated prices between the
4 pharmaceutical company and the payer/government entity in question would remain the preferred
5 solution, arbitration has the potential to help equalize the bargaining power of both parties of the
6 negotiation, while incentivizing negotiating parties to negotiate in good faith. If negotiations fail to
7 conclude with a price agreeable to both parties, they could submit to final offer arbitration or
8 conventional arbitration.
9

10 In final offer arbitration, the arbitrator would be given final bids by the drug manufacturer and the
11 payer/government entity in question. Such bids would be accompanied by data justifying the price
12 put forward by each party, and there would be potential for an independent third party to offer a
13 third price, which can be informed by value-based price benchmarks, comparative effectiveness
14 research, and cost-effectiveness analysis. The arbitrator under final offer arbitration would be
15 required to choose one of three prices: 1) the bid of the drug manufacturer; 2) the bid of the
16 payer/government entity; or 3) the price submitted by the independent third party, if applicable.
17 Alternatively, under conventional arbitration, the arbitrator would not be tied to any of the bids or
18 options put forward; they could select any price they believe is fair.¹⁷
19

20 Case Study: Germany
21

22 Germany uses arbitration as one potential pathway to determine the price of a drug in the German
23 market. After a drug is approved by the European Medicines Agency, allowing for the drug to be
24 sold in Germany, a drug manufacturer unilaterally sets the drug's price, applicable for 12 months.
25 At the same time, the manufacturer also is required to submit a report outlining the benefits of the
26 drug to the Federal Joint Committee, comprised of physicians, dentists, hospitals, and health
27 insurers (sickness funds). The Federal Joint Committee forwards the report to the non-
28 governmental Institute for Quality and Efficiency in Health Care (IQWiG), which conducts an
29 assessment of the clinical effectiveness and benefits of the new drug compared with one or more
30 comparator therapies. After the IQWiG submits its finding, the Federal Joint Committee issues a
31 final decision regarding the level of benefit of the new drug relative to existing therapies that treat
32 the condition in question. Such benefits can include prolonged life expectancy, reduction in side
33 effects, health status improvement, shortening of disease duration and quality of life improvement.
34 A drug is then assigned one of six benefit ratings:
35

- 36 1. Major added benefit
- 37 2. Considerable added benefit
- 38 3. Minor added benefit
- 39 4. Nonquantifiable added benefit
- 40 5. No evidence of added benefit
- 41 6. Lower benefit than comparator(s)

42 Depending on a drug's benefit rating, and whether there is a reference group to guide a reference
43 price of a drug, a drug manufacturer can either enter into negotiations with Germany's sickness
44 funds (health insurers), or be assigned to a therapeutic class subject to reference pricing – pricing
45 based on other drugs in the same therapeutic class, including generics. Drugs that enter into
46 negotiations have six months from the Federal Joint Committee decision to agree to a price. If they
47 cannot agree on a price, an arbitration panel is required to set a price within three months, which is
48 binding for the following year. Either party can challenge the decision, which would then trigger
49 IQWiG conducting a cost-benefit analysis. In addition, new findings can serve as cause for the
50 parties to revisit an agreement or arbitration decision after one year.^{18,19,20}
51

1 Relevant AMA Policy

2
3 Policy D-330.954 supports federal legislation which gives the Secretary of Health and Human
4 Services (HHS) the authority to negotiate contracts with manufacturers of covered Part D drugs;
5 and states that the AMA will work toward eliminating Medicare prohibition on drug price
6 negotiation and prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to
7 negotiate pharmaceutical pricing for all applicable medications covered by CMS. Policy H-155.962
8 states that our AMA opposes the use of price controls in any segment of the health care industry,
9 and continues to promote market-based strategies to achieve access to and affordability of health
10 care goods and services.

11
12 Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for
13 pharmaceuticals that are guided by the following principles: (a) value-based prices of
14 pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of
15 pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data
16 that incorporate rigorous scientific methods, including clinical trials, clinical data registries,
17 comparative effectiveness research, and robust outcome measures that capture short- and long-term
18 clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be
19 transparent, easily accessible to physicians and patients, and provide practicing physicians and
20 researchers a central and significant role; (d) processes to determine value-based prices of
21 pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to
22 determine value-based prices of pharmaceuticals should incorporate affordability criteria to help
23 assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based
24 pricing of pharmaceuticals should allow for patient variation and physician discretion. Policy
25 H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness analysis in
26 comparative effectiveness research. Policy H-460.909 outlines principles for creating a centralized
27 comparative effectiveness research entity.

28
29 *Leveraging an International Pricing Index*

30
31 Recent proposals put forward by the Administration and members of Congress attempt to lower US
32 drug costs by tying them to international prices, and/or would use an average of international
33 prices, or an international reference price, to help define whether a price of a drug is excessive. In
34 October of 2018, the Administration released an Advance Notice of Proposed Rulemaking
35 (ANPRM) for a proposal entitled “International Pricing Index Model for Part B Drugs.” The
36 ANPRM did not represent a formal proposal, but outlined the Administration’s current thinking
37 and sought stakeholder input on a variety of topics and questions related to this new drug pricing
38 model prior to entering formal rulemaking. At the time that this report was written, a proposed rule
39 on the international pricing index model was expected to be released, which has the potential to
40 differ markedly from what was outlined in the ANPRM.

41
42 The ANPRM outlined a new payment model for physician-administered drugs paid under
43 Medicare Part B that will transition Medicare payment rates for certain Part B drugs to lower rates
44 that are tied to international reference prices – referred to as the “international pricing index” –
45 except where the average sales price (ASP) is lower. The international reference price would partly
46 be based on an average of prices paid by other countries. To accomplish this, the proposal would
47 create a mandatory demonstration through the Centers for Medicare & Medicaid Innovation
48 (CMMI), which would apply to certain randomly selected geographic areas, representing
49 approximately 50 percent of Medicare Part B drug spending. Initially, the program would apply
50 only to sole-source drug products and some biologics for which there is robust international pricing
51 data available.

1 In geographic areas included in the demonstration, CMS would contract with private-sector
2 vendors that will negotiate for, purchase, and supply providers with drug products that are included
3 in the demonstration. CMS would directly reimburse the vendor for the included drugs, starting
4 with an amount that is more heavily weighted toward the ASP instead of the international pricing
5 index, and transitioning toward a target price that is heavily based on the international pricing
6 index. Providers would select vendors from which to receive included drugs, but would not be
7 responsible for buying from and billing Medicare for the drug product.
8

9 An alternative international drug price index has been put forward, which differs from that
10 introduced in the ANPRM: the Market-Based International Index (MBII). Unlike the international
11 price index included in the ANPRM, the MBII excludes developed countries with single-payer
12 health systems that use price controls. Therefore, unlike the index provided for the ANPRM, the
13 MBII does not include Canada, Finland, Greece, Italy, Spain, Sweden and the United Kingdom.
14 The MBII benchmark has two tiers. The first tier represents 60 percent of the benchmark, and
15 includes the Netherlands, Singapore and Switzerland – countries with truly market-based health
16 systems – as well as Denmark, which does not regulate drug prices. The second tier, which
17 constitutes 40 percent of the benchmark, includes Austria, Belgium, the Czech Republic, France,
18 Germany, Ireland, Japan, Portugal, and Slovakia – countries that have a mix of private and public
19 health insurance.²¹
20

21 Legislation has also been introduced in Congress that would use international drug prices to
22 determine whether a drug's price is excessive, trigger additional interventions, and serve as an
23 upper limit in drug price negotiations. Senator Bernie Sanders (I-VT) and Representative Ro
24 Khanna (D-CA) have introduced S 102/HR 465, the Prescription Drug Price Relief Act of 2019.
25 Notably, under the bill, the price of a prescription drug would be considered "excessive" if the
26 domestic average manufacturing price exceeds the median price for the drug in Canada, the United
27 Kingdom, Germany, France, and Japan. Even if a drug's price does not meet this criterion, or if
28 pricing information is unavailable in at least three of the five countries, a drug's price could still be
29 considered excessive if it is higher than reasonable in light of factors outlined in the legislation,
30 including cost, revenue, and the size of the affected patient population. If brand-name drugs are
31 found to be excessively priced, the drug would be included on a public excessive price database.
32 Open, nonexclusive licenses would be issued for the drug; and review of corresponding
33 applications for generic drugs and biosimilar biological products would be expedited to facilitate
34 competition as well as the entry of lower-cost options into the marketplace.^{22,23}
35

36 In addition, Congressman Frank Pallone (D-NJ) has introduced HR 3, the Lower Drug Costs Now
37 Act of 2019. The legislation would incorporate an international price average as part of authorizing
38 the Secretary of HHS to negotiate drug prices, limited to drugs that lack competition and have the
39 greatest financial impact to the Medicare program and the US health system as a whole, as well as
40 insulin. The Secretary of HHS would directly negotiate with drug manufacturers to establish a
41 maximum fair price for drugs selected for negotiation, which would be applied to Medicare, with
42 flexibility for Medicare Advantage and Medicare Part D plans to use additional tools to negotiate
43 even lower prices. In addition, the drug manufacturer would be required to offer the negotiated
44 price to private group and individual health insurance plans. An "average international market
45 price" would be established to serve as an upper limit for the price reached in any negotiation, if
46 practicable for the drug at hand, defined as no more than 120 percent of the drug's volume-
47 weighted net average price in six countries – Australia, Canada, France, Germany, Japan and the
48 United Kingdom. There would be a financial penalty if a pharmaceutical manufacturer does not
49 participate in or comply with the negotiations.
50

1 Relevant AMA Policy and Advocacy

2
3 Pursuant to AMA Policy, the AMA submitted comments in response to the “International Pricing
4 Index Model for Part B Drugs” in December 2018. Policy H-155.962 opposes the use of price
5 controls in any segment of the health care industry, and continues to promote market-based
6 strategies to achieve access to and affordability of health care goods and services. Policy
7 H-110.983 advocates that any revised Medicare Part B Competitive Acquisition Program meet the
8 following standards to improve the value of the program by lowering the cost of drugs without
9 undermining quality of care:

10
11 • it must be genuinely voluntary and not penalize practices that choose not to participate;
12 • it should provide supplemental payments to reimburse for costs associated with special
13 handling and storage for Part B drugs;
14 • it must not reduce reimbursement for services related to provision/administration of Part B
15 drugs, and reimbursement should be indexed to an appropriate health care inflation rate;
16 • it should permit flexibility such as allowing for variation in orders that may occur on the
17 day of treatment, and allow for the use of (CAP)-acquired drugs at multiple office
18 locations;
19 • it should allow practices to choose from multiple vendors to ensure competition, and
20 should also ensure that vendors meet appropriate safety and quality standards;
21 • it should include robust and comprehensive patient protections which include preventing
22 delays in treatment, helping patients find assistance or alternative payment arrangements if
23 they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-
24 payment of patient copayments in a way that does not penalize the physician;
25 • it should not allow vendors to restrict patient access using utilization management policies
26 such as step therapy; and
27 • it should not force disruption of current systems which have evolved to ensure patient
28 access to necessary medications.

29
30 *Tying Pharmaceutical Pricing to Market Exclusivity*

31
32 Brand-name drugs have 20 years of patent protection from the date of filing, and also enjoy a
33 period of market exclusivity, depending on the type of drug. Orphan drugs – drugs to treat rare
34 diseases or conditions affecting less than 200,000 individuals in the US, or affecting more than
35 200,000 individuals but for which there is not a reasonable expectation that the sales of the drug
36 would recover the costs – have seven years of market exclusivity. Drugs deemed to be innovative
37 products that include an entirely new active ingredient – a new chemical – have five years of
38 market exclusivity. Six months of exclusivity are added to existing exclusivity periods once studies
39 on the effects of a drug upon children are submitted for Food & Drug Administration (FDA)
40 review and meet the statutory requirements. Biologic manufacturers have 12 years of exclusivity
41 for innovator (brand-name) products. Innovator biologics also have additional patent protection
42 that generally exceeds exclusivity period by a few years.²⁴

43
44 Exclusivity periods for pharmaceuticals are not tied to the list price at which they enter the market,
45 nor to the rate at which they increase in price from year to year. The Council notes that two
46 potential options have been proposed to more closely tie drug market exclusivity to pricing
47 behavior. First, a policy strategy has been put forward to implement contingent exclusivity periods
48 for new brand drugs. Under this policy option, drug manufacturers with a newly approved drug
49 would be able to set their list price at whatever they wish, but the length of the exclusivity period
50 would depend on whether their list price is reasonable, ie, if it aligns with the drug’s value.
51 Multiple options could be utilized to assess a drug’s value, including cost per quality-adjusted life

1 year (QALY), or a value-based price benchmark. Contingent exclusivity periods, therefore, could
2 potentially lengthen the exclusivity period for drugs with lower cost per QALY, and reduce the
3 exclusivity period for drugs priced too highly to align with their value. For example, in the case of
4 an innovator biologic, a biologic with a low cost per QALY could see its exclusivity period
5 extended to 15 years from 12 years, whereas a biologic priced too high relative to its value could
6 have its exclusivity period set to 7 years.²⁵

7
8 Second, Senator Richard Durbin (D-IL) and Representative Jared Golden (D-ME) introduced S
9 366/HR 1188, the Forcing Limits on Abusive and Tumultuous (FLAT) Prices Act, which would
10 shorten (but not automatically void) the Food, Drug, and Cosmetic Act market exclusivity period
11 for prescription drugs that experience sudden increases in price. Under the FLAT Prices Act, an
12 increase of the wholesale acquisition cost of a prescription drug of more than 10 percent over a
13 one-year period, more than 18 percent over a 2-year period, or more than 25 percent over a three-
14 year period would result in a reduction of market exclusivity of 180 days. For every five percent
15 increase over these thresholds, the market exclusivity would be reduced an additional 30 days.
16 Manufacturers would be required to report such price increase within 30 days of meeting the
17 criteria for a price increase. Failure to report within the allotted time would result in 30 days of
18 reduced exclusivity daily until the report is submitted. The Secretary of HHS would have discretion
19 to grant a waiver to a manufacturer if the Secretary determines that the price increase is justified
20 and does not unduly restrict patient access to the drug or impact public health.^{26,27}

21
22 Relevant AMA Policy
23

24 Policy H-110.987 supports legislation to shorten the exclusivity period for FDA pharmaceutical
25 products where manufacturers engage in anti-competitive behaviors or unwarranted price
26 escalations. The policy also supports drug price transparency legislation that requires
27 pharmaceutical manufacturers to provide public notice before increasing the price of any drug
28 (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and
29 provide justification for the price increase; legislation that authorizes the Attorney General and/or
30 the Federal Trade Commission to take legal action to address price gouging by pharmaceutical
31 manufacturers and increase access to affordable drugs for patients; and the expedited review of
32 generic drug applications and prioritizing review of such applications when there is a drug
33 shortage, no available comparable generic drug, or a price increase of 10 percent or more each year
34 or per course of treatment. In addition, it advocates for policies that prohibit price gouging on
35 prescription medications when there are no justifiable factors or data to support the price increase.
36 Finally, it states that our AMA will continue to monitor and support an appropriate balance
37 between incentives based on appropriate safeguards for innovation on the one hand and efforts to
38 reduce regulatory and statutory barriers to competition as part of the patent system.
39

40 Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for
41 pharmaceuticals that are guided by the following principles: (a) value-based prices of
42 pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of
43 pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data
44 that incorporate rigorous scientific methods, including clinical trials, clinical data registries,
45 comparative effectiveness research, and robust outcome measures that capture short- and long-term
46 clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be
47 transparent, easily accessible to physicians and patients, and provide practicing physicians and
48 researchers a central and significant role; (d) processes to determine value-based prices of
49 pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to
50 determine value-based prices of pharmaceuticals should incorporate affordability criteria to help

1 assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based
2 pricing of pharmaceuticals should allow for patient variation and physician discretion.
3

4 Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness
5 analysis in comparative effectiveness research. Finally, it supports direct purchasing of
6 pharmaceuticals used to treat or cure diseases that pose unique public health threats, including
7 Hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.
8

9 **DISCUSSION**

10 Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have
11 imposed on patients, on physician practices, and the broader health care system. Patients delay,
12 forgo, or ration their medication when treatments are cost-prohibitive, putting their health at risk.
13 At a time of significantly increasing drug prices, and the launch of products with high list prices,
14 the Council believes that more needs to be done to improve access to and lower the costs of
15 prescription drugs, without stifling innovation.
16

17 The Council has long prioritized the importance of competition and transparency in the
18 pharmaceutical marketplace, and believes that negotiation of drug prices between drug
19 manufacturers and payers should continue to be the preferred mechanism to determine how drugs
20 are covered and paid for. That being said, the Council recognizes that there are multiple situations
21 in which payers have weakened bargaining power, due to a drug's lack of competition in the
22 marketplace. In addition, there is often limited recourse following an unjustifiable price hike of a
23 prescription medication, leaving patients questioning whether they will be able to afford
24 their medication. As such, the Council recommends policies to promote reasonable pricing
25 behavior in the pharmaceutical marketplace, as an alternative to price controls.
26

27 First, the Council recommends principles to guide the use of arbitration in determining the price of
28 prescription drugs, which build upon existing policy in favor of drug price negotiation, and
29 opposed to price controls. Of note, arbitration can serve a role in many circumstances, from
30 negotiating drug prices in Medicare Part D, to any negotiations that take place following a drug
31 product's market entry, as executed in Germany. The Council believes that arbitration should be
32 used for pharmaceuticals that have insufficient competition; have high list prices; or have
33 experienced unjustifiable price increases. Using arbitration will help rebalance the importance of
34 prescription drug affordability with the need for innovation, as an alternative to the status quo,
35 which allows unilateral price setting of drugs by manufacturers without regard to patient access and
36 affordability. Importantly, arbitration provides an incentive for drug manufacturers and
37 payers/government entities to arrive at a negotiated price.
38

39 To ensure that there is a pathway to use arbitration in Medicare Part D, the Council recommends
40 the reaffirmation of Policy D-330.954, which supports removing the current prohibition that
41 restricts the Secretary of HHS from being able to negotiate drug prices in Part D. In whatever
42 setting arbitration for drug prices is used, the Council underscores that the process should be
43 overseen by objective, independent entities, which would have the authority to select neutral
44 arbitrators or an arbitration panel, with strong conflict-of-interest protections built in.
45

46 The Council believes that as part of the arbitration process, and to guide the results, the use of
47 comparative effectiveness research and cost-effectiveness analysis will be critical. Related, the
48 arbitration process should include the submission of a value-based price benchmark for the drug in
49 question to inform the arbitrator's decision, pursuant to Policy H-110.986.
50

1 The Council stresses that arbitration should be coupled with additional policy proposals that
2 promote value and encourage competition within the pharmaceutical marketplace. The Council
3 believes that incorporating a drug's value and cost-effectiveness as factors in determining its length
4 of market exclusivity has the potential to promote increased competition for therapies that are
5 priced too high in relation to their clinical effectiveness and overall value. As such, the Council
6 recommends support for the use of contingent exclusivity periods for pharmaceuticals, which
7 would tie the length of the exclusivity period of a drug product to its cost-effectiveness at its list
8 price at the time of market introduction.

9
10 Finally, with the introduction of proposals that would use the average of a drug's price
11 internationally to serve as an upper limit in drug price negotiations, set a drug's price in Medicare
12 Part B or determine whether a drug's price is "excessive" to trigger additional interventions, the
13 Council recommends safeguards to ensure that such international drug price averages are used in a
14 way that uphold market-based principles and preserve patient access to necessary medications. In
15 addition, the Council recommends reaffirmation of Policy H-110.983 outlining standards for any
16 revised Medicare Part B Competitive Acquisition Program, which is relevant considering recent
17 proposals to incorporate an international pricing index in Medicare Part B.

18
19 The Council believes that the recommendations of this report add to the already large body of
20 AMA policies that address the high cost of prescription medications, which guide AMA advocacy
21 efforts to improve patient access to medication while reducing their costs and balancing the need
22 for appropriate innovation incentives. Pursuant to these policies, the AMA supports: (1) requiring
23 manufacturer and pharmaceutical supply chain transparency; (2) increasing competition and
24 curtailing anti-competitive practices; (3) ensuring prescribers have accurate point-of-care coverage
25 and patient cost-sharing information as part of their workflow including in the electronic health
26 record; and (4) streamlining and modernizing the utilization control methods used by health
27 insurers in response to higher prescription drug costs.

28
29 **RECOMMENDATIONS**
30

31 The Council on Medical Service recommends that the following be adopted and that the remainder
32 of the report be filed:

33
34 1. That our American Medical Association (AMA) advocate that the use of arbitration in
35 determining the price of prescription drugs meet the following standards to lower the cost of
36 prescription drugs without stifling innovation:

37
38 a. The arbitration process should be overseen by objective, independent entities;
39 b. The objective, independent entity overseeing arbitration should have the authority to select
40 neutral arbitrators or an arbitration panel;
41 c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to
42 minimize actual and potential conflicts of interest to ensure that they do not undermine the
43 integrity and legitimacy of the arbitration process;
44 d. The arbitration process should be informed by comparative effectiveness research and cost-
45 effectiveness analysis addressing the drug in question;
46 e. The arbitration process should include the submission of a value-based price benchmark
47 for the drug in question to inform the arbitrator's decision;
48 f. The arbitrator should be required to choose either the bid of the pharmaceutical
49 manufacturer or the bid of the payer/government entity;
50 g. The arbitration process should be used for pharmaceuticals that have insufficient
51 competition; have high list prices; or have experienced unjustifiable price increases; and

1 h. The arbitration process should include a mechanism for either party to appeal the
2 arbitrator's decision. (New HOD Policy)

3

4 2. That our AMA advocate that any use of international price indices and averages in determining
5 the price of and payment for drugs should abide by the following principles:

6

7 a. Any international drug price index or average should exclude countries that have single-
8 payer health systems and use price controls;

9 b. Any international drug price index or average should not be used to determine or set a
10 drug's price, or determine whether a drug's price is excessive, in isolation;

11 c. The use of any international drug price index or average should preserve patient access to
12 necessary medications; and

13 d. The use of any international drug price index or average should limit burdens on physician
14 practices. (New HOD Policy)

15

16 3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which
17 would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its
18 list price at the time of market introduction. (New HOD Policy)

19

20 4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B
21 Competitive Acquisition Program meet certain outlined standards to improve the value of the
22 program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD
23 Policy)

24

25 5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing
26 programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the
27 cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
28 (Reaffirm HOD Policy)

29

30 6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized
31 comparative effectiveness research entity. (Reaffirm HOD Policy)

32

33 7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward
34 eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Centers for Medicare & Medicaid Services. National Health Expenditures 2017 Highlights. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

² Yu N, Atteberry P and Bach P. Spending On Prescription Drugs In The US: Where Does All The Money Go? Health Affairs Blog. July 31, 2018. Available at <https://www.healthaffairs.org/do/10.1377/hblog20180726.670593/full/>.

³ IQVIA Institute for Human Data Science. Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023. May 2019.

⁴ Sisko A, Keehan S, Poisal J, Cuckler G, Smith S, Madison A, Rennie K and Hardesty J. National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth. Health Affairs, February 2019.

⁵ Schondelmeyer S and Purvis L. Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update. AARP Public Policy Institute. June 2019. Available at: <https://www.aarp.org/content/dam/aarp/ppi/2019/06/trends-in-retail-prices-of-specialty-prescription-drugs-year-end-update.doi.10.26419-2Fppi.00073.001.pdf>.

⁶ IQVIA, *supra* note 3.

⁷ IQVIA, *supra* note 3.

⁸ Medicare Payment Access Commission. Report to the Congress: Medicare Payment Policy. March 2019. Available at: http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf?sfvrsn=0.

⁹ Medicare Payment Access Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2019. Available at: http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

¹⁰ Kaiser Family Foundation. Medicaid's Prescription Drug Benefit: Key Facts. May 2019. Available at: <https://www.kff.org/medicaid/fact-sheet/medicaiids-prescription-drug-benefit-key-facts/>.

¹¹ Medicaid and CHIP Payment and Access Commission. Medicaid Drug Spending Trends. February 2019. Available at: <https://www.macpac.gov/wp-content/uploads/2019/02/Medicaid-Drug-Spending-Trends.pdf>.

¹² Kaiser Family Foundation and Health Research & Educational Trust. Employer Health Benefits: 2018 Annual Survey. Available at: <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>.

¹³ Cubanski, J, Damico, A and Neuman T. Medicare Part D: A First Look at Prescription Drug Plans in 2019. Kaiser Family Foundation. October 2018. Available at: <https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2019/>.

¹⁴ IQVIA, *supra* note 3.

¹⁵ Kirzinger A, Lopes L, Wu B and Brodie M. KFF Health Tracking Poll – February 2019: Prescription Drugs. March 2019. Available at: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>.

¹⁶ IQVIA, *supra* note 3.

¹⁷ The National Coalition on Health Care. Capitol Hill Briefing: Is Arbitration a Solution to High Drug Prices? February 25, 2019. Available at: <https://nchc.org/events/congressional-briefing-on-binding-arbitration/>.

¹⁸ Stern A, Pietrulla F, Herr A, Kesselheim A, and Sarpatwari A. The Impact Of Price Regulation On The Availability Of New Drugs In Germany. Health Affairs. 38, no. 7 (2019): 1182–1187.

¹⁹ NCHC, *supra* note 17.

²⁰ Robinson J, Panteli D, and Ex P. Single-Payer Drug Pricing In A Multipayer Health System: Does Germany Offer A Model For The US? Health Affairs Blog. March 2019. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20190318.475434/full/>.

²¹ Roy, A. What Medicare Can Learn From Other Countries on Drug Pricing. The Foundation for Research on Equal Opportunity. January 2019. Available at: <https://freopp.org/what-medicare-can-learn-from-other-countries-on-drug-pricing-bf298d390bc5>.

²² S 102, the Prescription Drug Price Relief Act of 2019. Available at: <https://www.congress.gov/116/bills/s102/BILLS-116s102is.pdf>.

²³ HR 465, the Prescription Drug Price Relief Act of 2019. Available at: <https://www.congress.gov/116/bills/hr465/BILLS-116hr465ih.pdf>.

²⁴ US Food and Drug Administration. Frequently Asked Questions on Patents and Exclusivity. Available at: <https://www.fda.gov/drugs/development-approval-process-drugs/frequently-asked-questions-patents-and-exclusivity>

²⁵ Pearson S, Nichols L, Chandra A. Policy Strategies For Aligning Price And Value For Brand-Name Pharmaceuticals. Health Affairs Policy Options Paper. March 2018. <https://www.healthaffairs.org/do/10.1377/hpb20180216.92303/full/>.

²⁶ S 366, the Forcing Limits on Abusive and Tumultuous (FLAT) Prices Act. Available at: <https://www.congress.gov/116/bills/s366/BILLS-116s366is.pdf>.

²⁷ HR 1188, the Forcing Limits on Abusive and Tumultuous (FLAT) Prices Act. Available at: <https://www.congress.gov/116/bills/hr1188/BILLS-116hr1188ih.pdf>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-19)

Introduced by: Medical Student Section

Subject: Ensuring Fair Pricing of Drugs Developed with the United States Government

Referred to: Reference Committee J

1 Whereas, The United States spends almost twice as much on healthcare as other comparable
2 high income countries despite similar utilization rates, driven in part by higher spending on
3 prescription drugs than other comparable nations^{1,2,3,4,5,6,7}; and
4

5 Whereas, The United States spends between 30% and 190% more on pharmaceutical drugs
6 per capita as compared to other comparable high income countries despite similar utilization
7 rates^{3,4,5,6}; and
8

9 Whereas, Many drugs cost significantly more in the United States than in other comparable
10 industrialized countries, imposing an undue financial burden on American consumers of
11 pharmaceutical compounds, particularly the uninsured, Medicare beneficiaries, and those
12 whose insurance plans do not cover medicines they need^{3,4,5,6,7,8}; and
13

14 Whereas, The United States government is the world's largest funder of the basic science
15 research that supports the development of new pharmaceutical compounds^{9,10,11}; and
16

17 Whereas, The United States government licenses drugs discovered in its laboratories to for-
18 profit entities in order to facilitate commercialization^{12,13,14}; and
19

20 Whereas, Numerous examples exist of drugs funded in whole or in part by the US government
21 being sold in the United States for higher prices than in other comparable industrialized
22 countries^{3,15,16,17,18,19,20,21,22,23}; and
23

24 Whereas, Pharmaceutical companies and industry advocacy groups excuse high prices by
25 explaining they are necessary for research and development of new drugs^{25,26,27}; and
26

27 Whereas, A report by the US Government Accountability Office found that pharmaceutical sales
28 increased by 45% globally over the period from 2006 to 2015 and two thirds of pharmaceutical
29 companies saw their profit margins increase over that time period, while annual research and
30 development investment in the United States increased by only 8% over the period from 2008 to
31 2014²⁸; and
32

33 Whereas, Pharmaceutical companies have a higher average profit margin than all comparable
34 industries, including software development which is often cited as a similar industry with high
35 upfront R&D costs and low relative distribution costs^{28,29}; and
36

37 Whereas, The United States pays an estimated 70% of all pharmaceutical profits obtained from
38 OECD nations despite only accounting for 34% of the OECD's GDP³⁰; and

1 Whereas, While the 1980 Bayh-Dole Act grants US government agencies the authority to
2 unilaterally revoke licenses to companies or order that additional licenses be granted in order to
3 ensure access (so-called “march in rights”), this extraordinary power has never been used to
4 ensure fair pricing^{31,32,33}; and

5
6 Whereas, The NIH has repeatedly decided that it does not have the statutory authority to use its
7 march-in rights to force licensees to set fair prices for American consumers as this is under the
8 purview of Congress^{34,35,36}; and

9
10 Whereas, 29 European countries currently use a model called international reference pricing
11 (IRP) to set drug prices whereby insurers and/or socialized healthcare programs agree to pay a
12 maximum price for drugs set to an index of prices paid by comparable nations or use such an
13 index as a benchmark for negotiations to set prices^{37,38}; and

14
15 Whereas, Studies of the effectiveness of IRP have found that it lowers prices, increases
16 utilization of drug classes to which the model is applied, and reduces expenditures with no
17 negative effects on health outcomes^{39,40,41,42,43}; and

18
19 Whereas, One of the most common concerns regarding IRP is that it may incentivize
20 pharmaceutical companies to delay or eliminate product launches in countries with a lower
21 willingness to pay^{44,45,46,47}; and

22
23 Whereas, Analyses of IRP's effects on pharmaceutical product launch delay have found the
24 effect is weak and is limited to countries with a lower willingness to pay^{48,49,50}; and

25
26 Whereas, The United States is one of the nations with the highest willingness to pay in
27 aggregate, implying IRP's tendency to delay pharmaceutical product launch in lower-income
28 countries would likely not apply to the United States^{8,9,47,48}; and

29
30 Whereas, The Institute for Medicare and Medicaid Innovation in the Department of Health and
31 Human Services (HHS) has proposed a new model for Medicare Part B reimbursement for
32 single-source pharmaceuticals and biologics to be phased into 50% of Medicare Part B plans
33 between 2020 to 2025 that shifts the reimbursement structure to an IRP model, using 126% of
34 the average price paid for a drug in 16 comparable OECD countries for which drug pricing
35 information is widely and publicly available as a benchmark^{2,49,50,51}; and

36
37 Whereas, Over the five years of its implementation, the proposed model is expected to save
38 \$17.2 billion overall including \$3.4 billion in direct out-of-pocket savings without changing
39 Medicare Part B's benefit structure^{50,51}; and

40
41 Whereas, The AMA has expressed concern that the involuntary nature of the trial program may
42 pose risks to patient access to necessary medications should third party vendors be unable to
43 negotiate prices for drugs that fall at or under Medicare's target price for reimbursement⁵²; and

44
45 Whereas, Existing AMA Policy (H-110.997, H-110.988, H-110.987, D-110.993, H-110.991,
46 D-110.988, H-110.998, D-330.954) highlights the AMA's continuing commitment to lowering
47 prescription drug costs, so long as physician freedom of choice is preserved and appropriate
48 incentives for pharmaceutical research and development are maintained; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to
2 read as follows:

3

4 **Pharmaceutical Costs, H-110.987**

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

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

12 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical
13 industry.

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

17 5. Our AMA encourages prescription drug price and cost transparency among
18 pharmaceutical companies, pharmacy benefit managers and health insurance companies.

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

21 7. Our AMA supports legislation to shorten the exclusivity period for biologics.

22 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies
23 and national medical specialty societies to develop principles to guide advocacy and
24 grassroots efforts aimed at addressing pharmaceutical costs and improving patient access
25 and adherence to medically necessary prescription drug regimens.

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

29 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical
30 manufacturers to provide public notice before increasing the price of any drug (generic,
31 brand, or specialty) by 10% or more each year or per course of treatment and provide
32 justification for the price increase; (b) legislation that authorizes the Attorney General and/or
33 the Federal Trade Commission to take legal action to address price gouging by
34 pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c)
35 the expedited review of generic drug applications and prioritizing review of such applications
36 when there is a drug shortage, no available comparable generic drug, or a price increase of
37 10% or more each year or per course of treatment.

38 11. Our AMA advocates for policies that prohibit price gouging on prescription medications
39 when there are no justifiable factors or data to support the price increase.

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

42 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical
43 products where manufacturers engage in anti-competitive behaviors or unwarranted price
44 escalations.

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

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

Received: 08/28/19

References:

1. Papanicolas I, Woskie LR, Jha AK. Health Care Spending in the United States Compared With 10 Other High-Income Countries. *JAMA*. 2018;319(10):990. doi:10.1001/jama.2018.1879.
2. National Health Expenditure Data. Centers for Medicare & Medicaid Services. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>. Published December 11, 2018. Accessed March 23, 2019.
3. Comparison of U.S. and International Prices for Top Medicare Part B Drugs by Total Expenditures. ASPE: OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION. <https://aspe.hhs.gov/system/files/pdf/259996/ComparisonUSInternationalPricesTopSpendingPartBDrugs.pdf>. Published October 25, 2018. Accessed April 16, 2019.
4. Sarnak DO, Squires D, Kuzmak G, Bishop S. Paying for Prescription Drugs Around the World: Why Is the US an Outlier? Paying for Prescription Drugs Around the World: Why Is the US an Outlier? Long Term Scorecard. http://www.longtermcarescorecard.org/~media/files/publications/issue-brief/2017/oct/sarnak_paying_for_rx_ib_v2.pdf. Published October 2017. Accessed March 19, 2019.
5. Health resources - Pharmaceutical spending - OECD Data. OECD.org. <https://data.oecd.org/healthres/pharmaceutical-spending.htm>. Published 2017. Accessed March 2, 2019.
6. Kesselheim AS, Avorn J, Sarpatwari A. The High Cost of Prescription Drugs in the United States. *JAMA Network*. <https://jamanetwork.com/journals/jama/article-abstract/2545691>. Published August 23, 2016. Accessed March 29, 2019.
7. Hirscher B. How the U.S. Pays 3 Times More for Drugs. *Scientific American*. <https://www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs/>. Published 2019. Accessed March 14, 2019.
8. Prescription Drug Spending in the U.S. Health Care System. American Academy of Actuaries. <http://www.actuary.org/content/prescription-drug-spending-us-health-care-system>. Published March 2018. Accessed March 21, 2019.
9. Wagner JL, McCarthy E. International Differences in Drug Prices. *Annual Review of Public Health*. 2004;25(1):475-495. doi:10.1146/annurev.publhealth.25.101802.123042.
10. Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers. Global Forum for Health Research. http://announcementsfiles.cohred.org/gfhr_pub/assoc/s14881e/s14881e.pdf. Published 2006. Accessed March 12, 2019.
11. Mervis J. Data check: U.S. government share of basic research funding falls below 50%. *Science*. <https://www.sciencemag.org/news/2017/03/data-check-us-government-share-basic-research-funding-falls-below-50>. Published December 8, 2017. Accessed March 23, 2019.
12. Licensing: Overview. Office of Technology Transfer. <https://www.ott.nih.gov/licensing>. Accessed March 29, 2019.
13. NIH Start-Up Exclusive License Agreements. Office of Technology Transfer. <https://www.ott.nih.gov/licensing/nih-start-exclusive-license-agreements>. Accessed March 23, 2019.
14. Why You May Want to Consider a Contract. National Institute of Allergy and Infectious Diseases. <https://www.niaid.nih.gov/grants-contracts/why-you-may-want-consider-contract>. Published February 10, 2016. Accessed March 19, 2019.
15. Xalatan January 29 2004 Petition. Essential Inventions. <http://www.essentialinventions.org/legal/xalatan-xalatan-29jan04petition.pdf>. Published January 29, 2004. Accessed March 12, 2019.
16. Doggett L, Sanders B, Welch P, et al. Congressional Letter to NIH and HHS Regarding Xtandi. Bernie Sanders U.S. Senate. <https://www.sanders.senate.gov/download/congressional-letter-to-nih-and-hhs-regarding-xtandi?inline=file>. Published March 28, 2016. Accessed March 2, 2019.
17. Wyden-Grassley Sovaldi Investigation Finds Revenue-Driven Pricing Strategy Behind \$84,000 Hepatitis Drug. United States Senate Committee On Finance. <https://www.finance.senate.gov/ranking-members-news/wyden-grassley-sovaldi-investigation-finds-revenue-driven-pricing-strategy-behind-84-000-hepatitis-drug>. Published December 1, 2015. Accessed March 17, 2019.
18. Evans D. The Fair Pricing Coalition (FPC) applauds the Wyden-Grassley US Senate bipartisan Sovaldi investigation spotlighting a greed-driven pricing strategy behind Gilead's \$1,000 per pill hepatitis C drug launch. Fair Pricing Coalition. https://fairpricingcoalition.org/tag/sovaldi/?doing_wp_cron=1553611638.5101399421691894531250. Published December 3, 2015. Accessed March 13, 2019.
19. Re: Intent To Grant an Exclusive License of U.S. Government-Owned Patents for patents on Zika Virus Vaccine and Methods of Production to Sanofi Pasteur, Inc. KEI Online. <https://www.keionline.org/wp-content/uploads/Zika-Army-21Dec2016.pdf>. Published December 21, 2016. Accessed March 16, 2019.
20. Datlof BM. US Army to KEI Letter Re: Sanofi Zika Vaccine. KEI Online. <https://www.keionline.org/wp-content/uploads/2017-04-21-US-Army-to-KEI-Letter-RE-Sanofi-Zika-Vaccine.pdf>. Published April 21, 2017. Accessed March 8, 2019.
21. Silverman E. The Battle Over a Fair Price for Zika Vaccines. *Scientific American*. <https://www.scientificamerican.com/article/the-battle-over-a-fair-price-for-zika-vaccines/>. Published May 18, 2017. Accessed March 23, 2019.
22. Struver Z. How Sanofi Prices Its MS Drug Aubagio (Teriflunomide) in the U.S. and Five Reference Countries. KEI Online. <https://www.keionline.org/23328>. Published April 29, 2017. Accessed March 18, 2019.
23. PETITION TO USE AUTHORITY UNDER BAYH-DOLE ACT TO PROMOTE ACCESS TO RITONAVIR, SUPPORTED BY NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES CONTRACT NO. AI27220. Essential Inventions. <http://www.essentialinventions.org/legal/norvir/norvir-29jan04petition.pdf>. Published January 29, 2004. Accessed March 9, 2019.
24. Guha AM. Prices for Abbott's Norvir (generic name Ritonavir) as a Standalone Product in 2010. KEI Online. <https://www.keionline.org/prices/ritonavir>. Published August 12, 2010. Accessed March 18, 2019.
25. Emanuel EJ. Big Pharma's Go-To Defense of Soaring Drug Prices Doesn't Add Up. *The Atlantic*. <https://www.theatlantic.com/health/archive/2019/03/drug-prices-high-cost-research-and-development/585253/>. Published March 23, 2019. Accessed April 17, 2019.
26. Pharmaceutical Industry Profits And Research And Development. *Health Affairs Blog*. https://www.healthaffairs.org/do/10.1377/hblog20171113.880918/full/#_edn1. Published November 13, 2017. Accessed April 17, 2019.
27. 2018 JANSSEN U.S. TRANSPARENCY REPORT. Janssen. <http://jnj-janssen.brightspotcdn.com/a8/cf/733a04f14fc0acd931b36b337182/2018-janssen-us-transparency-report.pdf>. Published March 2019. Accessed April 17, 2019.

28. Government Accountability Office, Dicken JE, Richard O. *DRUG INDUSTRY: Profits, Research and Development Spending, and Merger and Acquisition Deals.*; 2017:1-53. <https://www.gao.gov/assets/690/688472.pdf>. Accessed April 17, 2019.
29. Anderson R. Pharmaceutical industry gets high on fat profits. BBC News. <https://www.bbc.com/news/business-28212223>. Published November 6, 2014. Accessed April 17, 2019.
30. Council of Economic Advisors. *Reforming Biopharmaceutical Pricing at Home and Abroad*. https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf?mod=article_inline. Accessed April 17, 2019.
31. Love J. KEI Briefing Note 2017:1. Bayh-Dole Act and difference between March-In Rights and the world wide royalty free rights in patents. KEI Online. <https://www.keionline.org/24132>. Published February 5, 2018. Accessed March 26, 2019.
32. Thomas JR. March-In Rights Under the Bayh-Dole Act. FAS. <https://fas.org/sgp/crs/misc/R44597.pdf>. Published August 22, 2016. Accessed March 15, 2019.
33. Bayh-Dole Regulations. Office of Extramural Research. <https://grants.nih.gov/grants/bayh-dole.htm>. Published July 1, 2013. Accessed March 29, 2019.
34. Zerhouni EA. March-In Position Paper in the case of Norvir. Office of Technology Transfer. <https://www.ott.nih.gov/sites/default/files/documents/policy/March-In-Norvir.pdf>. Published July 29, 2004. Accessed March 18, 2019.
35. Zerhouni EA. March-In Position Paper in the case of Xalatan. Office of Technology Transfer. <https://www.ott.nih.gov/sites/default/files/documents/policy/March-In-xalatan.pdf>. Published September 17, 2004. Accessed March 18, 2019.
36. Collin F. March-In Determination in the case of norvir (November 2013). Office of Technology Transfer. <https://www.ott.nih.gov/sites/default/files/documents/policy/March-In-Norvir2013.pdf>. Published November 1, 2013. Accessed March 18, 2019.
37. Oğuzhan GE. Impact of the International Reference Pricing on Pharmaceutical Market Access. *Pharmaceutical Market Access in Developed Markets*. 2018:255-259. doi:10.7175/747.ch16.
38. Ruggeri K, Nolte E. Pharmaceutical pricing: The use of external reference pricing. *Rand health quarterly*. 2013;xi-58. https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR240/RAND_RR240.pdf. Accessed April 16, 2019.
39. Robinson JC, Panteli D, Ex P. Reference Pricing in Germany: Implications for U.S. Pharmaceutical Purchasing | Commonwealth Fund. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/reference-pricing-germany-implications>. Published February 4, 2019. Accessed April 17, 2019.
40. Schneeweiss S. Reference drug programs: Effectiveness and policy implications. *Health Policy*. 2007;81(1):17-28. doi:10.1016/j.healthpol.2006.05.001.
41. Brekke KR, Grasdal AL, Holmås TH. Regulation and pricing of pharmaceuticals: Reference pricing or price cap regulation? *European Economic Review*. 2009;53(2):170-185. doi:10.1016/j.eurocorev.2008.03.004.
42. Galizzi MM, Ghislandi S, Miraldo M. Effects of Reference Pricing in Pharmaceutical Markets. *PharmacoEconomics*. 2011;29(1):17-33. doi:10.2165/11537860-00000000-00000.
43. Lee JL-Y, Fischer MA, Shrank WH, Polinski JM, Choudhry NK. A Systematic Review of Reference Pricing: Implications for US Prescription Drug Spending. Scholars at Harvard. https://scholar.harvard.edu/nkc/files/2012_reference_pricing_systematic_review_ajmc.pdf. Published November 2012. Accessed April 16, 2019.
44. Richter A. Assessing the Impact of Global Price Interdependencies. *PharmacoEconomics*. 2008;26(8):649-659. doi:10.2165/00019053-200826080-00003.
45. Danzon P, Epstein A. Effects of Regulation on Drug Launch and Pricing in Interdependent Markets. *The National Bureau of Economic Research*. December 2011. doi:10.3386/w14041.
46. Maini L, Pammolli F. Reference Pricing as a Deterrent to Entry: Evidence from the European Pharmaceutical Market. Scholars at Harvard. https://scholar.harvard.edu/files/lucamaini/files/reference_pricing_as_a_deterrent_to_entry.pdf. Published December 30, 2017. Accessed April 17, 2019.
47. Varol N, Costa-Font J, McGuire A. Does Adoption of Pharmaceutical Innovation Respond to Changes in the Regulatory Environment? *Applied Economic Perspectives and Policy*. 2012;34(3):531-553. doi:10.1093/aapp/pps027.
48. Houy N, Jelovac I. Drug Launch Timing and International Reference Pricing. *Health Economics*. 2014;24(8):978-989. doi:10.1002/hec.3078.
49. Best D. Answering Your Questions about the IPI Drug Pricing Model. HHS.gov. <https://www.hhs.gov/blog/2018/10/30/answering-your-questions-about-the-ipi-drug-pricing-model.html>. Published November 1, 2018. Accessed April 17, 2019.
50. U.S. Department of Health and Human Services. What You Need to Know about President Trump Cutting Down on Foreign Freeloading. HHS.gov. <https://www.hhs.gov/about/news/2018/10/25/ipi-policy-brief.html>. Published October 25, 2018. Accessed April 17, 2019.
51. Medicare Program; International Pricing Index for Medicare Part B Drugs. Washington, D.C. Center for Medicare and Medicaid Services. October 30, 2018. *Federal Register*. October 30, 2018; 83(210):54546-54561.
52. Madara JL. Re: Advance Notice of Proposed Rulemaking: Medicare Program; International Pricing Index Model for Medicare Part B Drugs. December 2018.

RELEVANT AMA POLICY

Cost of Prescription Drugs H-110.997

Our AMA:(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in

making these choices; (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products; (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies; (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies; (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Citation: BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep. 3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: BOT Rep. 14, A-18

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Citation: Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: BOT Rep. 14, A-18

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.

Citation: CMS Rep. 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Appended: Res. 201, A-17 Reaffirmed in lieu of: Res. 207, A-17 Modified: Speakers Rep. 01, A-17 Appended: Alt. Res. 806, I-17 Reaffirmed: BOT Rep. 14, A-18 Appended: CMS Rep. 07, A-18 Appended: BOT Rep. 14, A-19 Reaffirmed: Res. 105, A-19

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Citation: CMS Rep. 3, I-04 Modified: CMS Rep. 1, A-14 Reaffirmation A-14 Reaffirmed in lieu of Res. 229, I-14

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.

Citation: CMS Rep. 6, A-03 Appended: Res. 107, A-07 Reaffirmed in lieu of: Res. 207, A-17 Appended: Alt. Res. 806, I-17 Reaffirmed: BOT Rep. 14, A-18 Appended: CMS Rep. 07, A-18 Reaffirmation: A-19 Appended: Res. 126, A-19

Prescription Drug Price and Cost Transparency D-110.988

1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.

Citation: Alt. Res. 806, I-17

Cost of New Prescription Drugs H-110.998

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

Citation: Res. 112, I-89 Reaffirmed: Res. 520, A-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Citation: Res. 211, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14 Reaffirmed: CMS Rep. 2, I-15 Appended: Res. 203, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-19)

Introduced by: Indiana

Subject: Protecting Seniors from Medicare Advantage Plans

Referred to: Reference Committee J

1 Whereas, Medicare Advantage plans are heavily marketed to seniors by insurance companies,
2 with less than ideal transparency in advertising; and
3
4 Whereas, These plans produce higher insurance company profits at cost to CMS because
5 Advantage plans are paid at a higher rate than traditional Medicare; and
6
7 Whereas, There also is the potential for higher annual and lifetime costs for the patient under an
8 Advantage Plan; and
9
10 Whereas, Presentations by insurance company officials to seniors can overemphasize the value
11 of different options and can create confusion; therefore be it
12
13 RESOLVED, That our American Medical Association encourage AARP, insurance companies
14 and other vested parties to develop simplified tools and guidelines for comparing and
15 contrasting Medicare Advantage plans. (New HOD Policy)

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

Received: 09/27/19

RELEVANT AMA POLICY

<https://policysearch.ama-assn.org/policyfinder/detail/comparing%20Medicare%20Advantage%20Plans?uri=%2FAMADoc%2FHOD.xml-H-285.902.xml>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-19)

Introduced by: International Medical Graduates Section

Subject: Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard

Referred to: Reference Committee J

1 Whereas, Patients in the United States spend more on prescription medications than any other
2 industrialized country according to the National Healthcare Expenditure, 333 billion dollars in
3 2017, up from 236 billion dollars in 2007; and

4
5 Whereas, Increases in prescription drug prices have resulted in many patients foregoing
6 medication and putting lives at risk; while other countries such as Britain, the world's 20 top
7 selling medications are three times cheaper than in the United States; and

8
9 Whereas, Data from a study of generic and brand name drug costs published in Health Affairs in
10 January 2019 shows that generic drugs and brand name drugs increased in price from 9 to 21
11 percent per annum from 2005 through 2016; and

12
13 Whereas, Up to 85% of the raw ingredients used in the medications sold in the United States
14 are produced outside of the country while our prices for pharmaceuticals per capita are the
15 highest in the world; and

16
17 Whereas, Recent efforts to create an International Pricing Index to allow the Centers for
18 Medicaid and Medicare to negotiate prices for medications in Part B, which leaves the majority
19 of medications prescribed that are in Medicare Part D and from other sources unaffected; and

20
21 Whereas, New legislation efforts are focusing on the creation of an International Pricing Index
22 that would identify only the 250 most costly medications each year and negotiate prices for only
23 25 of these medications per annum, would continue to leave the majority of medications
24 unaffected; and

25
26 Whereas, The current legislative proposal would cap the price of medications at 120% of an
27 International Pricing Index for only 25 medications each year, which may potentially still result in
28 consumers experiencing an unfair burden of medication prices for the majority of medications;
29 and

30
31 Whereas, The AMA is dedicated to promoting patient-centered quality healthcare that is
32 accessible and affordable; it would be in the best interest for patient care and to minimize cost
33 to better control medication prices; therefore be it

1 RESOLVED, That our American Medical Association advocate for legislation to create an
2 International Pricing Index that would track global medication prices for all prescription
3 medications and keep U.S. medication costs aligned with prices paid in other countries to help
4 control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take
5 Action); and be it

6
7 RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged
8 fairly for prescription medications based on the International Pricing Index and that additional
9 costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)

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

Received: 10/01/19

References:

- 1) "Spending On Prescription Drugs In The US: Where Does All The Money Go?", Health Affairs Magazine; <https://www.healthaffairs.org/doi/10.1377/hlthaff.20180726.670593/full/>
- 2) "Retail prescription drug spending grew by \$90 billion over four years," Modern Healthcare; <https://www.modernhealthcare.com/technology/retail-prescription-drug-spending-grew-90-billion-over-four-years>
- 3) "The Contribution Of New Product Entry Versus Existing Product Inflation In The Rising Costs Of Drugs," Health Affairs; <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05147#EX1>
- 4) "International Pricing Index: Outsourcing Negotiations Will Continue the US Drug Cost Crisis", Health Affairs Magazine; <https://www.healthaffairs.org/doi/10.1377/hlthaff.20190307.887201/full/>
- 5) "More Than 300 Groups Seek Halt to CMS Plans for Global Drug Pricing Index", American Journal of managed Care; <https://www.ajmc.com/newsroom/more-than-300-groups-seek-halt-to-cms-plans-for-global-drug-pricing-index>
- 6) "Why are Prescription Drug Prices Rising?" U.S. News & World Report, <https://health.usnews.com/health-care/for-better/articles/2019-02-06/why-are-prescription-drug-prices-rising>
- 7) "How the U.S. Pays 3 Times More for Drugs", Scientific American: <https://www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs/>

RELEVANT AMA POLICY

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.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

- (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
- (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
- (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
- (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost Sharing Arrangements for Prescription Drugs H-110.990

Our AMA:

- 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
- 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
- 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.

Citation: CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18

Drug Issues in Health System Reform H-100.964

The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.

(2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.

(3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.

(4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the substitution of FDA B-rated generic drug products.

(5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.

(6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.

(7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.

(7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.

(8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance.

(9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs.

(10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic incentives can interfere with pharmacist professional judgment.

(11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.

(12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public

disclosure of patient and reporter identities.

(13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.

(14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.

(15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses.

(16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.

(17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies.

Citation: (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)

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, housestaff 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.

Citation: (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)

Patient and Public Education about Cost of Care H-155.980

The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.

Citation: (Res. 153, I-89; Sub. Res. 42, I-89; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 1, A-15)

Medicare Part B Competitive Acquisition Program (CAP) H-110.983

Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

(1) it must be genuinely voluntary and not penalize practices that choose not to participate;

(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;

(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;

(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;

(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;

(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;

(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and

(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

Citation: Res. 216, I-18

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

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.

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Maximum Allowable Cost of Prescription Medications H-155.962

Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.

Citation: CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmation: A-17

Managed Care Cost Containment Involving Prescription Drugs H-285.965

- (1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.
- (2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-

containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withhold or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a chance to discuss the change with the patient.

(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.

(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.

(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.

(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.

(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.

(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.

(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.

(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed.

(12) For physicians who do not have electronic access, hard copies must be available.

Citation: CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res. 714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19

Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises H-250.988

Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability.

Citation: (Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12)

1.2.13 Medical Tourism

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patients decision to seek health care abroad. (IV, V, VI)

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

- (a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
- (b) Advocate for education for health care professionals about medical tourism.
- (c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
- (d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

- (e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individuals concerns and wishes about care.
- (f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
- (g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.
- (h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
- (i) Offer their best professional guidance about a patients decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patients best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
- (j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physicians prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
 - (i) the nature and duration of the patient-physician relationship;
 - (ii) the likely impact on the individual patients well-being;
 - (iii) the burden declining to provide follow-up care may impose on fellow professionals;
 - (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

AMA Principles of Medical Ethics: IV, V, VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-19)

Introduced by: Medical Student Section

Subject: Support for Housing Modification Policies

Referred to: Reference Committee J

1 Whereas, Falls amongst the elderly population cost approximately 30,000 lives and nearly \$32
2 billion every year¹; and
3
4 Whereas, For US adults ages 65 and older in 2012, there were 24,190 deaths and 3.2 million
5 non-fatal, fall-related injuries²; and
6
7 Whereas, US citizens with low socioeconomic status or greater neighborhood disadvantage had
8 higher rates of falls⁷; and
9
10 Whereas, Minorities, those with lower levels of education, and those with less social support
11 were less likely to have home modifications⁸; and
12
13 Whereas, Blacks were 30-40% less likely than whites to have fall-related injuries when
14 controlling for these differences⁹; and
15
16 Whereas, Home modifications led by an occupational therapist had the greatest potential to
17 affect the most elderly when compared to six other fall prevention strategies, including Tai Chi,
18 Otago, medication management, Vitamin D supplements, expedited first eye cataract surgery,
19 and single-vision distance lenses for outdoor activities¹⁰; and
20
21 Whereas, Homes are the most likely setting of falls in the elderly with high morbidity and
22 mortality and prevention in the single most effective intervention^{5,18,19}; and
23
24 Whereas, Home hazards to the elderly include physical limitations, loose rugs, unstable
25 furniture, obstructed walkways, and poor lighting give way to falls within the home²⁰; and
26
27 Whereas, Simple modifications aimed at increasing lighting and tacking down loose rugs or
28 carpets have shown to statistically reduce the risk of falling in the home¹⁶; and
29
30 Whereas, Other interventions include grab bars and grips in the bathroom, hand-rails on both
31 sides of the steps, and lever-style handles on doors and faucets, wheelchair ramps, stair lifts,
32 first-floor bathroom or kitchen renovations, and other more extensive renovations²¹; and
33
34 Whereas, There are currently three insurance-based funding schemes for housing
35 modifications, including Medicare Advantage, Medicaid's Money Follows the Person Initiative,
36 and the Veteran's Health Administration Home Improvements and Structural Alterations (HISA)
37 benefits; and

1 Whereas, Housing modifications are comparatively clinically effective, cost effective, and
2 actionable in preventing fall related injuries among the elderly; therefore be it
3
4 RESOLVED, That our American Medical Association support legislation for health insurance
5 coverage of housing modification benefits for: (a) the elderly; (b) other populations that require
6 these modifications in order to mitigate preventable health conditions, including but not limited to
7 the disabled or soon to be disabled; and (c) other persons with physical and/or mental
8 disabilities. (New HOD Policy)

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

Date Received: 10/01/19

References:

1. Gielen AC, McDonald EM, Shields W. *Unintentional Home Injuries Across the Life Span: Problems and Solutions.*; 2015. doi:10.1146/annurev-publhealth-031914-122722
2. Burns ER, Stevens JA, Lee R. The direct costs of fatal and non-fatal falls among older adults — United States. *J Safety Res.* 2016. doi:10.1016/j.jsr.2016.05.001
3. Hoffman GJ, Hays RD, Shapiro MF, Wallace SP, Ettner SL. The Costs of Fall-Related Injuries among Older Adults: Annual Per-Faller, Service Component, and Patient Out-of-Pocket Costs. *Health Serv Res.* 2017. doi:10.1111/1475-6773.12554
4. Degrauw X, Annest JL, Stevens JA, Xu L, Coronado V. Unintentional injuries treated in hospital emergency departments among persons aged 65 years and older, United States, 2006-2011. *J Safety Res.* 2016. doi:10.1016/j.jsr.2015.11.002
5. American College of Surgeons. *National Trauma Data Bank 2012 Annual Report.*; 2012.
6. Cubanski J, Neuman T. The Facts on Medicare Spending and Financing. Henry J. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>. Published 2018. Accessed February 6, 2019.
7. Lo AX, Rundle AG, Buys D, et al. Neighborhood Disadvantage and Life-Space Mobility Are Associated with Incident Falls in Community-Dwelling Older Adults. *J Am Geriatr Soc.* 2016. doi:10.1111/jgs.14353
8. Meucci MR, Gozalo P, Dosa D, Allen SM. Variation in the Presence of Simple Home Modifications of Older Americans: Findings from the National Health and Aging Trends Study. *J Am Geriatr Soc.* 2016. doi:10.1111/jgs.14252
9. Sun DQ, Huang J, Varadhan R, Agrawal Y. Race and fall risk: Data from the National Health and Aging Trends Study (NHATS). *Age Ageing.* 2016. doi:10.1093/ageing/afv173
10. Stevens JA, Lee R. The Potential to Reduce Falls and Avert Costs by Clinically Managing Fall Risk. *Am J Prev Med.* 2018;55(3):290-297. doi:10.1016/j.amepre.2018.04.035
11. Kamei T, Kajii F, Yamamoto Y, et al. Effectiveness of a home hazard modification program for reducing falls in urban community-dwelling older adults: A randomized controlled trial. *Jpn J Nurs Sci.* 2015;12(3):184-197. doi:10.1111/jjns.12059
12. Elliott S, Leland NE. Occupational Therapy Fall Prevention Interventions for Community-Dwelling Older Adults: A Systematic Review. *Am J Occup Ther.* 2018;72(4):7204190040p1-7204190040p11. doi:10.5014/ajot.2018.030494
13. Albert SM, Raviotta J, Lin CJ, Edelstein O, Smith KJ. Cost-effectiveness of a statewide falls prevention program in Pennsylvania: Healthy Steps for Older Adults. *Am J Manag Care.* 2016;22(10):638-644. <http://www.ncbi.nlm.nih.gov/pubmed/28557514>.
14. Albert SM, King J, Boudreau R, Prasad T, Lin CJ, Newman AB. Primary prevention of falls: effectiveness of a statewide program. *Am J Public Health.* 2014;104(5):e77-84. doi:10.2105/AJPH.2013.301829
15. Carnemolla P, Bridge C. A scoping review of home modification interventions – Mapping the evidence base. *Indoor Built Environ.* February 2018;1420326X1876111. doi:10.1177/1420326X18761112
16. Josephson DA Rubenstein, LZ KRF. Home safety and fall prevention. *Clin Geriatr Med.* 1991.
17. Gillespie LD, Robertson MC, Gillespie WJ, et al. Interventions for preventing falls in older people living in the community. *Cochrane Database Syst Rev.* 2012. doi:10.1002/14651858.CD007146.pub3
18. Sterling DA, O'Connor JA, Bonadies J. Geriatric falls: Injury severity is high and disproportionate to mechanism. *J Trauma - Inj Infect Crit Care.* 2001. doi:10.1097/00005373-200101000-00021
19. Connell BR, Wolf SL. Environmental and behavioral circumstances associated with falls at home among healthy elderly individuals. *Arch Phys Med Rehabil.* 1997. doi:10.1016/S0003-9993(97)90261-6
20. Carter SE, Campbell EM, Sanson-Fisher RW, Redman S, Gillespie WJ. Environmental hazards in the homes of older people. *Age Ageing.* 1997. doi:10.1093/ageing/26.3.195
21. Joint Center for Housing Studies of Harvard University. *Housing America's Older Adults Meeting the Needs of an Aging Population.*; 2014.
22. U. S. Centers for Medicare & Medicaid Services. Speech: Remarks by Administrator Seema Verma at the America's Health Insurance Plans (AHIP) 2018 National Conference on Medicare. <https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-americas-health-insurance-plans-ahip-2018-national>. Published 2018.
23. Jaffe S. New Medicare Advantage Benefits Are Supposed To Help Seniors Stay Out Of The Hospital. NPR. <https://www.npr.org/sections/health-shots/2018/11/09/665767905/new-medicare-advantage-benefits-are-supposed-to-help-seniors-stay-out-of-the-hos>. Published 2018.
24. U. S. Centers for Medicare & Medicaid Services. Money Follows the Person. <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>. Published 2016.
25. Semeah LM, Ahrentzen S, Jia H, Cowper Ripley DC, Levy CE, Mann WC. The Home Improvements and Structural Alterations Benefits Program: Veterans With Disabilities and Home Accessibility. *J Disabil Policy Stud.* 2017.

doi:10.1177/1044207317696275

26. National Multiple Sclerosis Society. Home Modification Assistance Enacted State Legislation. <https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Advocacy/Home-Modification-Assistance-Enacted-Legislation-UPDATED-June-2018.pdf>. Published 2018. Accessed February 16, 2019.
27. 115th Congress. H.R.1780 - Senior Accessible Housing Act. <https://www.congress.gov/bill/115th-congress/house-bill/1780?r=33>.

RELEVANT AMA POLICY

Community-Based Falls Prevention Programs H-25.988

Our American Medical Association will work with relevant organizations to support community-based falls prevention programs.

Citation: (Res. 408, A-15)

Exercise Programs for the Elderly H-25.995

The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients' exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program.

Citation: (CSA Rep. C, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Health Care for Older Patients H-25.999

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

Citation: (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-11; Appended: Res. 709, A-13)

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 the 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.

Citation: CMS Rep. A, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CMS Rep. 01, A-18;

5.1 Advance Care Planning

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often

thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patients individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

- (a) Regularly encourage all patients, regardless of age or health status, to:
 - (i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);
 - (ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;
 - (iii) make their views known to their designated surrogate and to (other) family members or intimates.
- (b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.
- (c) Explain how advance directives, as written articulations of patients preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogates responsibilities in decision making. Involve the patients surrogate in this conversation whenever possible.
- (d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.
- (e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patients medical records accordingly when preferences have changed to ensure that these continue to reflect the individuals current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patients surrogate in these reviews whenever possible.

AMA Principles of Medical Ethics: I,IV

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject: Addressing the Need for Low Vision Aid Devices
Referred to: Reference Committee J

1 Whereas, An estimated 1,082,790 patients in the United States live with a vision of 20/200 or
2 worse, constituting severe visual disability, and the incidence of low vision and blindness is
3 expected to more than double in the next 30 years;¹ and
4
5 Whereas, Visual disability and blindness negatively impact patients' educational opportunities,
6 income, and economic prospects;² and
7
8 Whereas, Visual disability is determined by low vision specialists (optometrist, ophthalmologist,
9 or occupational therapist) based on decreased (relative to age-norms) measures of visual
10 ability, including best corrected visual acuity, contrast sensitivity, and/or visual fields combined
11 with a validated visual functioning questionnaire score (e.g., National Eye Institute Visual
12 Functioning questionnaire or Impact of Visual Impairment Scale); and
13
14 Whereas, Vision rehabilitation services provide critical guidance, education, and devices to
15 patients with visual impairment, including low vision aids (LVA) (magnifying lenses, electronic
16 magnifiers, smartphone applications for text reading) that help individuals improve or maximize
17 their remaining vision;² and
18
19 Whereas, Vision rehabilitation with LVAs has been shown to have a positive impact on visual
20 functioning in up to 45 to 50 percent of patients with low vision;³ and
21
22 Whereas, LVAs offered to veterans through the Veterans Affairs hospital system showed
23 significant improvement in all levels of visual function, including reading, mobility, and visual
24 motor skills;⁴ and
25
26 Whereas, Vision rehabilitation service consultation by trained clinicians are currently covered by
27 Medicare;⁵ and
28
29 Whereas, Historically, Medicare by statute does not cover LVAs, as the US Center for Medicare
30 and Medicaid Services has interpreted a statute stating that Medicare will not cover eye glasses

¹ Chan T, Friedman DS, Bradley C, Massof R. Estimates of Incidence and Prevalence of Visual Impairment, Low Vision, and Blindness in the United States. *JAMA Ophthalmol*. 2018;136(1):12-19.

² Huber J, Jutai J, Strong G, Plotkin A. The Psychosocial Impact of Closed-Circuit Televisions on Persons with Age-Related Macular Degeneration. *J Vis Impair Blind* 2008;102:690-701.

³ Judith E. Goldstein, OD; Mary Lou Jackson, MD; Sandra M. Fox, OD; James T. Deremeik, CLVT; Robert W. Massof, PhD; for the Low Vision Research Network Study Group. Clinically Meaningful Rehabilitation Outcomes of Low Vision Patients Served by Outpatient Clinical Centers. *JAMA Ophthalmol*. 2015;133(7):762-769.

⁴ Joan A. Stelmack, OD, MPH; X. Charlene Tang, MD, PhD; Domenic J. Reda, PhD; Stephen Rinne, MA; Rickilyn M. Mancil, MA; Robert W. Massof, PhD; for the LOVIT Study Group. Outcomes of the Veterans Affairs Low Vision Intervention Trial (LOVIT). *Arch Ophthalmol*. 2008;126(5):608-617.

⁵ The Blind Guide. Medicare for People with Low Vision. Accessed March 13, 2019. Available at: <https://www.theblindguide.com/medicare-low-vision/>.

1 for beneficiaries, except in the setting of vision correction after cataract surgery, to include
2 LVAs;^{6,7} and
3
4 Whereas, LVAs have been shown to be more impactful on low vision patients' visual functioning
5 than either power wheelchairs or support canes, which are currently paid for by Medicare under
6 the durable medical equipment benefit;⁸ and
7
8 Whereas, Visual impairment is more likely to be present in older patients, patients in poverty,
9 and in patients with risk factors such as diabetes, indicating that a large number of patients with
10 visual impairment rely on Medicare and/or Medicaid for health care services coverage;⁹ and
11
12 Whereas, LVAs can cost hundreds to thousands of dollars if purchased out-of-pocket;¹⁰ and
13
14 Whereas, A greater need for services for patients with low vision is expected to rise,
15 necessitating strategic allocation of resources and policy planning;¹¹ therefore be it
16
17 RESOLVED, That our American Medical Association support legislative and regulatory actions
18 promoting insurance coverage and adequate funding for low vision aids for patients with visual
19 disabilities. (Directive to Take Action)

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

Received: 10/02/19

⁶ 42 U.S.C. § 1395y(a)(7), SSA § 1862(a)(7).

⁷ 42 U.S.C. § 1395x(s)(3), SSA § 1861(s)(8).

⁸ Houston, K. Massachusetts Eye and Ear Outcomes Book: Vision Rehabilitation Service, Psychosocial Impact of Assistive Devices Scale (PIADS), Final Analysis. 2019.

⁹ Ko F, Vitale S, Chou CF, Cotch MF, Saaddine J, Friedman DS. Prevalence of nonrefractive visual impairment in US adults and associated risk factors, 1999-2002 and 2005-2008. *JAMA*. 2012;308(22):2361-2368.

¹⁰ Enhanced Vision. DaVinci Pro HD/OCR - Full Page Text-to-Speech. Accessed March 13, 2019. Available at: <https://www.enhancedvision.com/shop/davinci-pro-electronic-desktop-magnifier>.

¹¹ Chan T, Friedman DS, Bradley C, Massof R. Estimates of Incidence and Prevalence of Visual Impairment, Low Vision, and Blindness in the United States. *JAMA Ophthalmol*. 2018;136(1):12-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-19)

Introduced by: American Academy of Physical Medicine & Rehabilitation

Subject: Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs

Referred to: Reference Committee J

1 Whereas, Seat elevation is an accessory to power wheelchairs that assists an individual with
2 mobility impairment to raise and lower themselves in the seated position through the use of an
3 electromechanical lift system, and standing feature is an accessory that allows an individual to
4 transition from a seated position to a standing position without the need to transfer out of the
5 wheelchair; and

6 Whereas, These features provide individuals with significantly improved abilities to perform
7 mobility-related activities of daily living (MRADLs) and to function independently within the
8 home; and

9 Whereas, Seat elevation is especially important for assisting individuals with transfers to/from a
10 wheelchair to/from a commode, bed, or other surface with less risk of falls and shoulder and
11 other injuries secondary to long-term wheelchair use; and

12 Whereas, Standing feature has been demonstrated to both assist with MRADLs and provide
13 numerous medical benefits, including improved circulation, promotion of bone density, improved
14 GI tract function, improved mobility and lower limb function, reduced risk of contractures, and
15 reduced occurrence of pressure ulcers and skeletal deformities; and

16 Whereas, The Centers for Medicare and Medicaid Services' (CMS) National Coverage
17 Determination (NCD) for mobility assistance equipment (MAE) grants coverage for power
18 wheelchairs and other mobility devices when they are determined to be reasonable and
19 necessary for beneficiaries with personal mobility deficits to assist in the performance of
20 MRADLs; and

21 Whereas, HCFA Ruling 96-1 clearly states that accessories that are integral to wheelchairs are
22 considered DME and are part of the DME benefit; and

23 Whereas, The four DME Medicare Administrative Contractors (MACs) have taken the position
24 that both seat elevation and standing feature are non-covered benefits for Medicare
25 beneficiaries because they are not primarily medical in nature and, therefore, do not meet the
26 definition of DME; and

27 Whereas, CMS's position on seat elevation and standing feature stands in stark contrast to its
28 position that the tilt and recline feature in power wheelchairs is, in fact, considered primarily
29 medical in nature and has been since 2006; and

1 Whereas, The DME MACs' position on coverage of standing feature and seat elevation is
2 contrary to the NCD for MAE, ignores CMS national policy, and results in categorical denials
3 regardless of individual need; and
4
5 Whereas, Patients who are not eligible for Medicare, such as patients on Medicaid and patients
6 who receive health care benefits through commercial insurance, experience similar access and
7 coverage barriers, therefore be it
8
9 RESOLVED, That our American Medical Association request that the Centers for Medicare and
10 Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that
11 the seat elevation and standing features of power wheelchairs are primarily medical in nature
12 and qualify under the definition of durable medical equipment (DME) when used in a power
13 wheelchair (Directive to Take Action); and be it further
14
15 RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors
16 (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the
17 seat elevation and standing features in their power wheelchairs on an individual basis according
18 to the National Coverage Determination (NCD) for mobility assistance equipment (MAE),
19 activate the existing Healthcare Common Procedure Coding System (HCPCS) codes for seat
20 elevation and standing feature in power wheelchairs, and determine appropriate reimbursement
21 levels for these codes in order to facilitate access to these important benefits for Medicare
22 beneficiaries with mobility impairments (Directive to Take Action); and be it further
23
24 RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing
25 feature through its administrative authority, our AMA advocate before Congress to support
26 legislation that will clarify the DME benefit to include coverage, coding and reasonable
27 reimbursement of standing feature and seat elevation in power wheelchairs for appropriate
28 Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further
29
30 RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature
31 and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments.
32 (Directive to Take Action)

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

Received: 10/03/19

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-19

Subject: Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (Resolution 414-A-19)

Presented by: Michael M. Miller, MD, Chair

Referred to: Reference Committee K

1 Resolution 414-A-19, introduced by the Oklahoma Delegation and referred by the House of
2 Delegates asks:

3
4 That our American Medical Association offer guidance to medical staffs regarding patient use
5 of non-US Food and Drug Administration approved medical marijuana and cannabinoids on
6 hospital property, including product use, storage in patient rooms, nursing areas and/or
7 pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting.

8 9 METHODS

10 English language reports were selected from searches of the PubMed and Google Scholar databases
11 from January 2009 to August 2019 using the search terms: “hospital policies” and cannabis;
12 “hospital policies” and marijuana. Additional articles were identified by manual review of the
13 reference lists of pertinent publications. Web sites managed by federal agencies and applicable
14 professional organizations, including hospital associations, were reviewed for relevant information.

15
16 The Council on Science and Public Health acknowledges that the use of non-FDA approved
17 cannabis and cannabinoid products presents challenges in health care facilities beyond hospitals
18 (e.g., long-term care facilities, mental health and addiction facilities) and patients (e.g., visitors and
19 employees), but those issues were deemed outside of the scope of this report.

20 21 CURRENT AMA POLICY

22
23 The AMA believes that scientifically valid and well-controlled clinical trials conducted under
24 federal investigational new drug applications are necessary to assess the safety and effectiveness of
25 all new drugs, including potential cannabis products for medical use. Furthermore, cannabis for
26 medicinal use should not be legalized through the state legislative, ballot initiative, or referendum
27 process. The AMA also supports legislation ensuring or providing immunity against federal
28 prosecution for physicians who certify that a patient has an approved medical condition or
29 recommend cannabis in accordance with their state's laws and believes that effective patient care
30 requires the free and unfettered exchange of information on treatment alternatives and that
31 discussion of these alternatives between physicians and patients should not subject either party to
32 criminal sanctions (D-95.969, “Cannabis Legalization for Medicinal Use”).

33
34
35 The AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed
36 with the goal of facilitating the conduct of clinical research and development of cannabinoid-based
37 medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-

1 based medical cannabis programs, the legalization of cannabis, or that scientific evidence on the
2 therapeutic use of cannabis meets the current standards for a prescription drug product (H-95.952,
3 "Cannabis and Cannabinoid Research").

4

5 STATUS OF CANNABIS UNDER FEDERAL LAW

6

7 Under the U.S. Controlled Substances Act (CSA) of 1970, cannabis is classified as a Schedule I
8 controlled substance, meaning it has no currently accepted medical use in treatment in the United
9 States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.¹
10 This means that the cultivation, manufacture, sale distribution, and use of medical cannabis violates
11 the CSA and constitutes a federal felony.

12

13 Cannabis is not FDA-approved as a safe and effective drug for any indication. However, the
14 agency has approved three drug products containing synthetic versions of the main psychoactive
15 ingredient of cannabis, delta-9 tetrahydrocannabinol (THC). Marinol® and Syndros™, which
16 include the active ingredient dronabinol, are indicated for nausea and vomiting associated with
17 cancer chemotherapy and anorexia associated with weight loss in patients with AIDS.³ Cesamet®,
18 which contains the active ingredient nabilone, is also indicated for the treatment of the nausea and
19 vomiting associated with cancer chemotherapy.²

20

21 The Agriculture Improvement Act of 2018 (Farm Bill) removed hemp from the CSA, which means
22 that cannabis plants and derivatives that contain no more than 0.3 percent THC on a dry weight
23 basis are no longer controlled substances under federal law.² However, the law explicitly preserved
24 FDA's authority to regulate products containing cannabis or cannabis-derived compounds.² The
25 FDA has approved one cannabis-derived product, Epidiolex®, which contains a purified form of
26 the drug substance cannabidiol (CBD) for the treatment of seizures associated with Lennox-Gastaut
27 or Dravet syndrome.³ The FDA has expressed concern at the proliferation of products asserting to
28 contain CBD that are being marketed for therapeutic or medical uses that have not been approved
29 by FDA.³ Since CBD has been studied as a new drug, it cannot be legally included in foods or
30 dietary supplements. The FDA is currently considering potential regulatory frameworks for CBD.

31

32 STATUS OF CANNABIS UNDER STATE LAW

33

34 At the state level, trends in law have moved from decriminalization, to the legalization of medical
35 use of cannabis, to cannabis regulated for adult use.⁴ California was the first jurisdiction in the
36 United States to legalize the medical use of cannabis. Today, 33 states, the District of Columbia,
37 Guam, Puerto Rico, and the U.S. Virgin Islands have legalized the medical use of cannabis through
38 either the legislative process or ballot measures. These laws vary greatly by jurisdiction, from how
39 patients access the product (home cultivated or dispensary), to qualifying conditions, product safety
40 and testing requirements, packaging and labeling requirements, and consumption method (some
41 states prohibit smoking the product). In jurisdictions that have legalized cannabis for medicinal use,
42 physicians can "certify" or "recommend" a qualifying patient for the medicinal use of cannabis, but
43 physicians cannot prescribe cannabis for medical purposes because it is illegal under federal law. In
44 recent years, an additional 17 states have enacted laws allowing access to low THC/high CBD
45 products for children with epilepsy.

46

47 In 2012, Colorado and Washington were the first U.S. jurisdictions to legalize the adult use of
48 cannabis for recreational purposes. Today, a total of 11 states and the District of Columbia have
49 legalized cannabis for adult use. Most of these jurisdictions have created for-profit, commercial
50 cannabis production and distribution markets where the product is sold and taxed.

1 DISCUSSION

2

3 The AMA does not approve of state-based medical cannabis programs, the legalization of cannabis,
4 or that scientific evidence on the therapeutic use of cannabis meets the current standards for a
5 prescription drug product. Hospitals are being encouraged to accommodate patient use of
6 cannabis.⁵ The primary argument for allowing patients to use cannabis in hospitals is focused on
7 continuity of care. If patients have had success using cannabis for medicinal purposes, ending that
8 treatment due to a hospital admission disrupts treatment and could lead to worse outcomes.⁵

9

10 *Risks to Hospitals in Allowing Patient Use of Cannabis Products*

11

12 Hospitals are subject to federal law because they receive reimbursement from federal programs.
13 Since cannabis is a Schedule 1 controlled substance, its manufacture, distribution, or possession is
14 a criminal offense. Hospitals that allow patient use of cannabis are at risk of violating federal law,
15 losing their deemed status from Centers for Medicare and Medicaid Services (CMS), exposing
16 themselves to possible penalties or sanctions, and losing federal funding.⁶⁻⁸

17

18 Physicians who maintain DEA licensure are also subject to federal law and are not permitted to
19 prescribe a Schedule I substance. In addition to the prohibition on prescribing, the DEA also
20 prohibits a practitioner from administering a Schedule I substance, which means that physicians
21 and other clinicians with DEA licenses cannot administer cannabis. Doing so may jeopardize a
22 clinician's federal DEA registration and their ability to prescribe controlled substances.

23

24 In addition to federal law, hospitals must also meet standards for pharmacies and medication
25 management such as those established by hospital accreditation bodies.⁸ For example, The Joint
26 Commission Standard MM.03.01.05 on Medication Management requires that: "[t]he hospital
27 safely controls medications brought into the hospital by patients, their families, or licensed
28 independent practitioners."^{8,9}

29

30 This standard includes the following elements of performance:

31

- 32 • The hospital defines when medications brought into the hospital by patients, their families,
33 or licensed independent practitioners can be administered.⁹
- 34 • Before use or administration of a medication brought into the hospital by a patient, his or
35 her family, or a licensed independent practitioner, the hospital identifies the medication and
36 visually evaluates the medication's integrity.⁹
- 37 • The hospital informs the prescriber and patient if the medication brought into the hospital
38 by patients, their families, or licensed independent practitioners is not permitted.⁹

39

40 One of the biggest challenges for hospitals in meeting this standard for cannabis would likely be
41 identifying the medication and visually evaluating the medication's integrity.⁸ Depending on state
42 law, the patient may be enrolled in the state's cannabis for "medicinal use" program and have their
43 own supply from a state licensed manufacturer. However, the hospital would likely not want to
44 assume responsibility for vetting the substance or any adverse effects the patient experiences as a
45 result of the product.

46

47 Hospitals would also have to address medication storage concerns, particularly if cannabis products
48 should be stored with the pharmacy department and treated as a controlled substance, by security
49 personnel, or with the patient.¹⁰ There are also complicated logistics for self-administration of
50 cannabis by the patient or caregiver. Many hospitals have policies on self-administration of

1 medicines that permit patients to use their own medications only after identification and labeling by
2 pharmacy personnel.

3
4 Since many hospitals have policies prohibiting smoking on facility grounds, hospitals would have
5 to determine what preparations of cannabis would be allowed (e.g., oils or edibles).⁸ Hospitals
6 should also be prepared to provide information to their medical staffs on cannabis withdrawal
7 symptoms as well as possible cannabis or cannabinoid contraindications, drug interactions, or
8 possible adverse effects.

9
10 *State Laws Addressing Cannabis Use in Hospitals*

11
12 Some states have tried to address cannabis use in hospital facilities by amending their state laws.
13 Connecticut and Maine permit the use of cannabis by hospitalized patients and give some state-
14 level legal protection for clinicians who administer it. Connecticut law provides that a nurse shall
15 not be subject to arrest or prosecution, or penalized in any manner for administering cannabis to a
16 qualifying patient or research program subject in a hospital or health care facility licensed by the
17 Department of Public Health.¹¹

18
19 Maine has enacted protection for hospitals and long-term care facilities for use of edible cannabis
20 products, tinctures, and salves by an admitted patient who has been certified for use of cannabis
21 products under state law.¹² The law provides that hospitals and long-term care facilities are not
22 subject to prosecution, search, seizure or penalty in any manner, including but not limited to a civil
23 penalty or disciplinary action by an occupational or professional licensing board or entity, and may
24 not be denied any license, registration, right or privilege solely because the admitted patient
25 lawfully engages in conduct involving the medical use of cannabis.¹² These protections also apply
26 to officers or directors, employees or agents of a hospital or long-term care facility.¹²

27
28 Minnesota law provides that hospitals may adopt reasonable restrictions on use and storage of
29 cannabis.¹³ The restrictions may include a provision that the provider will not store or maintain the
30 patient's supply of cannabis, that the provider is not responsible for providing cannabis for patients,
31 and that cannabis be used only in a place specified by the provider.¹³ Under Minnesota state law,
32 employees of these facilities are not subject to violations under the statutes for possession while
33 carrying out employment duties, such as providing or supervising care to a registered patient, or
34 distribution of cannabis to a registered patient.¹⁴

35
36 The Minnesota Hospital Association (MHA) convened a broad group of stakeholders to discuss the
37 impact of the state's cannabis law on hospital workflows as well as policies and procedures.¹⁵ The
38 group produced template policies on cannabis for MHA members. The policies can be summarized
39 as follows: (1) the hospital will not allow patient use of cannabis, (2) the hospital will allow
40 inpatients to continue use while inpatient in the hospital and cannabis will be treated as self-
41 administered home therapy, and (3) the hospital will allow inpatients to continue while inpatient in
42 the hospital and cannabis will be treated as a medication and integrated within the hospital medical
43 workflows.¹⁵ The templates provide hospitals with a helpful list of issues for consideration.

44
45 CONCLUSION

46
47 It is the AMA's position that scientifically valid and well-controlled clinical trials conducted under
48 federal investigational new drug applications are necessary to assess the safety and effectiveness of
49 all new drugs, including potential cannabis products for medical use. The AMA does not believe
50 cannabis for medicinal use should be legalized through the state legislative, ballot initiative, or
51 referendum process. Given the growing number of states that have legalized cannabis use, hospitals

1 are increasingly likely to encounter patients who are taking cannabis or cannabis-related products.
2 It has been argued that patients should be allowed to use non-FDA approved cannabis-related
3 products to ensure continuity of care if they are admitted to the hospital. However, hospitals and
4 physicians face legal risks in doing so given cannabis' status as a Schedule I controlled substance.
5 Hospitals should consider the risks associated with allowing the use of non-FDA approved
6 cannabis or cannabis-derived products by patients and develop policies to address this issue so
7 patients and clinicians have clarity on what is permitted. Hospitals that decide to allow the use of
8 non-FDA approved cannabis or cannabis-derived products should provide information to their
9 medical staffs on cannabis withdrawal symptoms as well as possible cannabis or cannabinoid
10 contraindications, drug interactions, or possible adverse effects.

11

12 RECOMMENDATIONS

13

14 The Council recommends that the following recommendation be adopted in lieu of Resolution 414-
15 A-19, and the remainder of the report be filed.

16

17 The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but
18 not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance
19 diversion prevention, as well as relevant state and federal agencies in developing policies for
20 addressing patient use of non-FDA approved cannabis or cannabis-derived products for use
21 within their facilities and (2) communicate their policy on patient use of non-FDA approved
22 cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared
23 to treat patients in accordance with policy. (New HOD Policy)

Fiscal Note: less than \$500

REFERENCES

1. 21 USC 812.
2. Agriculture Improvement Act of 2018, Pub. L. 115-334.
3. U.S. Food and Drug Administration, FDA Regulation of Cannabis and Cannabis-Derived Products: Questions and Answers. Available at <https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-questions-and-answers>. Accessed August 1, 2019.
4. The National Academies of Sciences Engineering and Medicine. The health effects of cannabis and cannabinoids: Current state of evidence and recommendations for research. Washington, DC: The National Academies Press. 2017.
5. Elnahal S. and Brown J. To Fulfill Their Mission, Health Care Facilities Should Better Accommodate Cannabis Patients. *Health Affairs Blog*. July 23, 2019. Available at <https://www.healthaffairs.org/do/10.1377/hblog20190719.709108/full/>. Accessed August 15, 2019.
6. Tyrrell R. and Keenan C. Medical marijuana: The hospital leader's to-do list. Advisory Board, April 16, 2019.
7. Borgelt LM, Franson KL. Considerations for Hospital Policies Regarding Medical Cannabis Use. *Hosp Pharm*. 2017;52(2):89–90. doi:10.1310/hpj5202-89.
8. Bridgeman MB, Abazia DT. Medicinal Cannabis: History, Pharmacology, And Implications for the Acute Care Setting. *P T*. 2017;42(3):180–188.
9. Joint Commission Standard MM.03.01.05.
10. Joint Commission Standard MM.03.01.01.
11. Connecticut Gen. Stat. 21a-408c.
12. Maine Rev. Stat. 558-C §2430-C.
13. Issue Brief: Medical Cannabis in Health Care Facilities. Minnesota Department of Health Information Bulletin 15-04. November 2015. Available at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib15_4.html. Accessed August 15, 2019.
14. Minn. Stat. Sec. 152.34.
15. Minnesota Hospital Association. Quality & Patient Safety: Medical Cannabis. Available at <https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-improvement-topics/medication-safety/medical-cannabis>. Accessed August 15, 2019.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923
(I-19)

Introduced by: Michigan

Subject: Support Availability of Public Transit Systems

Referred to: Reference Committee K

1 Whereas, Existing American Medical Association policy states that "climate changes will create
2 conditions that affect public health, with disproportionate impacts on vulnerable populations,
3 including children, the elderly, and the poor" (H-135.938), and supports "maximum feasible
4 reduction of all forms of air pollution" (H-135.998); and

5 Whereas, A shift from personal car use to public transport use can cause a six-fold decrease in
6 greenhouse gas emissions; and

7 Whereas, The Lancet Commission on Pollution and Health has concluded that pollution can be
8 controlled by switching to an economy that relies on public transport and discourages private
9 car use in cities; and

10 Whereas, Cities whose citizens utilize their public transit networks, averaging 50 or more transit
11 trips per year, have half the average fatalities from traffic compared to cities with an average of
12 20 transit trips per year; and

13 Whereas, A study that modeled the potential health effects of switching 40 percent of private
14 vehicle transport to alternative transport in a 1.1-million-person metropolitan area showed that
15 per year 508 deaths were prevented due to increased physical activity, 21 deaths were
16 prevented by avoiding traffic fatalities, and 13 deaths were prevented due to improved air
17 conditions; and

18 Whereas, The implementation of a new transit system has been shown to generate new
19 physical activity and decrease body mass indexes among new users; and

20 Whereas, In addition to improving air quality and reducing negative effects on the environment,
21 public transport can increase health care access for underserved populations and geographical
22 areas; and

23 Whereas, Rural cancer patients who lack a car are often unable to access their radiation and
24 chemotherapy treatments in neighboring towns and cities; and

25 Whereas, 78 percent of people with disabilities have challenges accessing transportation for
26 health care services, and public transportation improves the quality of life and independence of
27 young adults with disabilities; and

28 Whereas, Ride share programs such as Uber are not legally required to adhere to Americans
29 With Disabilities Act guidelines, which eliminates yet another mode of transportation for people
30 with disabilities; and

1 Whereas, Use of public transport by the elderly is associated with decreased depressive
2 symptoms, reduced feelings of loneliness, increased contact with friends and children, and
3 increased volunteering; therefore be it

4
5 RESOLVED, That our American Medical Association amend current policy H-135.939, "Green
6 Initiatives and the Health Care Community," by addition and deletion as follows:

7
8 Our AMA supports: (1) responsible waste management and clean energy
9 production policies that minimize health risks, including the promotion of appropriate
10 recycling and waste reduction; (2) the use of ecologically sustainable products,
11 foods, and materials when possible; (3) the development of products that are non-
12 toxic, sustainable, and ecologically sound; (4) building practices that help reduce
13 resource utilization and contribute to a healthy environment; and (5) the
14 establishment, expansion, and continued maintenance of affordable, reliable public
15 transportation; and (6) community-wide adoption of 'green' initiatives and activities
16 by organizations, businesses, homes, schools, and government and health care
17 entities (New HOD Policy); and be it further

18
19 RESOLVED, That our AMA amend current policy H-425.993, "Health Promotion and Disease
20 Prevention," by addition and deletion as follows:

21
22 The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco,
23 alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness;
24 (2) advocates intensified leadership to promote better health through prevention; (3)
25 believes that preventable illness is a major deterrent to good health and accounts
26 for a major portion of our country's total health care expenditures; (4) actively
27 supports appropriate scientific, educational and legislative activities that have as
28 their goals: (a) prevention of smoking and its associated health hazards; (b)
29 avoidance of alcohol abuse, particularly that which leads to accidental injury and
30 death; (c) reduction of death and injury from vehicular and other accidents; and (d)
31 encouragement of healthful lifestyles and personal living habits; and (5) advocates
32 that health be considered one of the goals in transportation planning and policy
33 development including but not limited to the establishment, expansion, and
34 continued maintenance of affordable, reliable public transportation; and (6) strongly
35 emphasizes the important opportunity for savings in health care expenditures
36 through prevention. (Modify Current HOD Policy)

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

Received: 10/03/19

Sources:

1. Chester, M. and Cano, A. Time-based life-cycle assessment for environmental policymaking: Greenhouse gas reduction goals and public transit. *Transportation Research*. 2016;43:49-58.
2. Landrigan, P. et al. The Lancet Commission on Pollution and Health. *The Lancet Commissions*. 2018;391(10119):462-512.
3. Litman, T. *Safer Than You Think*. Victoria Transport Policy Institute. July 24, 2018.
4. Xia, T. et al. Traffic-Related Air Pollution and Health Co-benefits of Alternative Transport in Adelaide, South Australia. *Environ Int*. 2015;74:281-90.
5. MacDonald, J. et al. The Effect Of Light Rail Transit on Body Mass Index and Physical Activity. *American Journal of Preventive Medicine*. 2010;39:2:105-112.
6. Charlton, M. et al. Challenges of Rural Cancer Care in the United States. *Oncology*. 2015;29(9)
7. Kurichi, J. et al. Perceived Barriers to Healthcare and Receipt of Recommended Medical Care Among Elderly Medicare Beneficiaries. *Arch Gerontol Geriatr*. 2017;72:45-51.
8. Lindsay, S. and Lamptey, D. Pedestrian Navigation and Public Transit Training Interventions for Youth with Disabilities: A Systematic Review. *Disabil Rehabil*. 2018;9:1-15.
9. Mapelli, E. Inadequate Accessibility: Why Uber Should Be a Public Accommodation Under the Americans With Disabilities Act. *Am Univ Law Rev*. 2018;67(6):1947-87.

10. Reinhard, E. et al. Public Transport Policy, Social Engagement and Mental Health in Older Age: A Quasi-Experimental Evaluation of Free Bus Passes in England. *J Epidemiol Community Health*. 2018;72(5):361-368.

RELEVANT AMA POLICY

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.

Citation: CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18;

Health Promotion and Disease Prevention H-425.993

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

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

See also:

[Global Climate Change and Human Health H-135.938](#)

[AMA Position on Air Pollution H-135.998](#)

[8.11 Health Promotion and Preventive Care](#)

[11.1.4 Financial Barriers to Health Care Access](#)

Education Materials

Speaker Information

SPS Education Program Flier

Speaker Slides (to be distributed after the program via e-mail)



S. Bobby Mukkamala, MD

Member, Board of Trustees
American Medical Association

S Bobby Mukkamala, MD, a board-certified otolaryngologist – head and neck surgeon, was elected to the American Medical Association Board of Trustees in June 2017. A graduate of the University of Michigan Medical School, he is in solo, private practice in Flint, Mich.

Dr. Mukkamala, who has been active in the AMA since residency, is a past Michigan representative to the AMA Young Physicians Section (YPS), a past recipient of the AMA Foundation's "Excellence in Medicine" Leadership Award and, for the last 13 years, a member of the Michigan delegation to the AMA House of Delegates. In 2009 he was elected to the AMA Council on Science and Public Health, and served as its chair from 2016 to 2017.

In addition to leadership roles at the AMA, Dr. Mukkamala has served as a member of the Michigan State Medical Society (MSMS) Board of Directors since 2011 and as board chair for the past two years. He is also a past president of the Genesee County Medical Society (GCMS) and continues to serve on the GCMS Board of Directors.

While a wide range of public health issues are important to Dr. Mukkamala, no issue strikes closer to home than his own city of Flint's nationally publicized struggles with high levels of lead leaching into the drinking water. As the immediate past chair of the Community Foundation of Greater Flint, he and the foundation's

board became the clearinghouse for funding projects focused on mitigating the effects of lead in local children. He now chairs the Foundation for Flint, a supporting organization of the Community Foundation that is working to increase access to high-quality early education for children—a proven strategy for helping children who have been exposed to lead.

Deeply committed to the revitalization of his hometown, Dr. Mukkamala returned to Flint after completing his residency at Loyola University Medical Center in Chicago in 2000. Today, he shares an office with his wife, Nita Kulkarni, MD, an obstetrician-gynecologist. Together, as a further demonstration of their dedication to Flint, in 2012 they established the Endowed Health Professions Scholarships at the University of Michigan, Flint.

Outside of medicine they enjoy family time with their twin teenaged sons, Deven and Nikhil, who are starting their college careers at the University of Chicago and University of Michigan, respectively.

2018–2019



Mihir Y. Parikh, MD

As the official team ophthalmologist of the San Diego Chargers since 2005, the founding medical director of Advanced Ophthalmology Institute and the chief surgeon of Nvision San Diego, Dr. Parikh knows the importance of vision and the demands for getting desired outcomes. Having undergone LASIK surgery himself, he understands the process, both as a surgeon and as a patient. Fellow physicians have voted him “Top Doc” of San Diego in ophthalmology, eight times, most recently in 2017.

As a board-certified ophthalmologist since 2002, Dr. Parikh has performed over 17,000 LASIK procedures, including many high profile patients such as athletes, NFL coaches, fellow eye doctors and elected officials. He specializes in LASIK, PRK, cataracts and intraocular lenses, corneal inlays and collagen crosslinking for keratoconus. He was one of the first West-Coast surgeons to use the IntraLase and custom Wavefront treatment technology. He was also one of the first surgeons to use femtosecond laser for cataract surgery and measure intraoperatively for lens implant accuracy.

Before dedicating his career to the field of medicine, ophthalmology and refractive eye surgery, Dr. Parikh was involved in laboratory research in molecular biology and biochemistry at the University of California, Irvine, and in clinical research at the University of California, San Diego Burn Center. He believes in science and progress.

An award-winning surgeon, Dr. Parikh was honored the Laurence Mehlman Prize and was the recipient of the University of California Regents Scholar Award for four years. His presentation as a corneal fellow on “The effects of intrastromal corneal lens implantation (Intacs) on nerve fiber layer thickness,” was honored as best paper of session at the ASCRS 2000 conference in Boston, Massachusetts.

In his spare time, Dr. Parikh teaches principles of ophthalmology and refractive surgery to fellow doctors and surgeons locally, nationally and internationally and he has been published in many notable medical journals. He also served as the past president of the San Diego County Medical Society and he is currently an elected delegate for San Diego County to the American Medical Association. He strongly believes that the sacred patient-physician bond is the secret to delivering customized outcomes in the evolving field of refractive eye surgery.

Join the AMA Senior Physicians Section (SPS) during the 2019 Interim Meeting



Register today!

Saturday, November 16

Manchester Grand Hyatt
San Diego, California

Room: Grand Hall C

11 a.m. - 12 p.m.

AMA Senior Physicians Section Assembly Meeting

- A light lunch will be offered at 11:30 a.m. — first come, first-served
- AMA House of Delegates' business items will be discussed along with future AMA SPS activities

12 - 1:30 p.m.

Senior Physicians Section Education Program, **'The Impact of Vision and Hearing Loss in the Senior Population—Why seeing and hearing are believing'**

Speakers:

- **Mihir Y. Parikh, MD**, is a board-certified ophthalmologist, former president of the San Diego County Medical Society, and chief surgeon for NVision San Diego.
- **S. Bobby Mukkamala, MD**, is a board-certified otolaryngologist—head and neck surgeon, elected to the American Medical Association Board of Trustees in June 2017.

Program Description: The quality of life for seniors is often linked to hearing and vision loss, which can be easily detected with simple testing. The majority of older adults will experience some changes in their sensory capacity. However, most elderly patients are unwilling to consider the use of hearing aids, which has been

shown to improve functional independence. This program will explore the links between age and sensory loss and ways to prevent its decline.

Objectives:

- Explain the importance of testing for hearing and vision loss as a person ages
- Review current screening tests available for hearing impairment
- Describe how hearing loss is associated with significant adverse effects on a person's social, psychological and physical well-being

We hope you can join us and enjoy the fellowship of your senior physician colleagues.



MEMBERSHIP
MOVES
MEDICINE™

Announcements

[SPS Governing Council Members](#)

[SPS Mission Statement](#)

[SPS Governing Council Nominations Flyer](#)

*For the best user experience, please download a copy of this handbook
to your personal device*

SENIOR PHYSICIANS

Senior Physicians Section (SPS) Governing Council

View the members responsible for directing the programs and activities of the Senior Physicians Section (SPS).

**Louis Weinstein, MD****Chair**

Specialty: Obstetrics & Gynecology

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
louis.weinstein@jefferson.eduConflict of Interest:
[PDF, 558.35 KB](#) [View full profile](#)**James F. Burdick, MD****Chair-elect**

Specialty: General Surgery

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
jburdic1@yahoo.comConflict of Interest:
[PDF, 564.38 KB](#) [View full profile](#)**Richard Allen, MD****Immediate Past Chair**

Specialty: Obstetrics & Gynecology

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
astorksnest@comcast.netConflict of Interest:
[PDF, 557.95 KB](#) [View full profile](#)**Barbara S. Schneidman, MD, MPH****Delegate**

Specialty: Psychiatry

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
bschneidman5@gmail.comConflict of Interest:
[PDF, 560.73 KB](#) [View full profile](#)**Luis T. Sanchez, MD****Alternate Delegate**

Specialty: Psychiatry

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
ltsanchez@verizon.netConflict of Interest:
[PDF, 193.22 KB](#) **Jenny L. Boyer, MD, PhD, JD****Officer-at-large**

Specialty: Psychiatry

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
jennyboyer@hotmail.comConflict of Interest:
[PDF, 563.21 KB](#) **Kenneth L. Mattox, MD****Officer-at-large**

Specialty: Thoracic Surgery

AMA Affiliations:
Senior Physicians Section
(SPS) Governing CouncilEmail:
redstart@aol.comConflict of Interest:
[PDF, 557.29 KB](#)

The AMA promotes the art and science of medicine and the betterment of public health.

AMA Careers
Events
Press Center

AMA Alliance
AMPAC
AMA Foundation

AMA Contact Us

Download AMA Connect app for [iPhone](#) or [Android](#)

The best in medicine, delivered to your mailbox

Email *

[JAMA NETWORK™](#) | [FREIDA™](#) | [AMA ED HUB™](#) | [AMA INSURANCE](#) | [AMA JOURNAL OF ETHICS®](#) | [CPT®](#) | [STORE](#) |
[AMA CREDENTIALING SERVICES](#) | [PHYSICIAN JOB LISTINGS](#)

[Terms of Use](#) | [Privacy Policy](#) | [Code of Conduct](#) | [Website Accessibility](#)

Copyright 1995 - 2019 American Medical Association. All rights reserved.

Mission Statement – Senior Physicians Section

To engage physicians age 65 and above, both active and retired, to promote policies, products and services relevant to senior physicians.

Mission Statement – American Medical Association

To promote the art and science of medicine and the betterment of public health.



MEMBERSHIP
MOVES
MEDICINE™

Call for nominations! Online Election Spring 2020

BECOME A LEADER OF THE AMA SENIOR PHYSICIANS SECTION

In January 2020, the American Medical Association Senior Physicians Section (SPS) Governing Council will issue a call for nominations. If you are interested in putting your experience to work, you are strongly encouraged to submit a nomination form.

Positions available

Nominations will be accepted for the following positions with terms commencing in June 2020, after the Annual Meeting.

- Delegate – two-year term (one position)
- Alternate Delegate – two-year term (one position)
- Officer At-Large – two-year term (one position)

Eligibility

All AMA physicians 65 years of age and older are members of the AMA Senior Physicians Section and are eligible for a leadership position, regardless of whether they work full time, part time or are retired.

For the Officer At-Large position, any current SPS member can stand for election, provided that (1) he or she has demonstrated experience in organized medicine by having held a prior elected leadership position at the local, state, specialty or national level; and (2) the candidate must also have attended an AMA meeting or had prior experience with the AMA's House of Delegates.

For the Delegate and Alternate Delegate position, a SPS member will be required to demonstrate experience in organized medicine by having held a prior leadership position(s) at the local, state, specialty society or national level. In addition, if the candidate currently holds an AMA-HOD Delegate or Alternate Delegate position, he or she must be willing to resign from that position if successfully elected as the Delegate or Alternate Delegate.

Election

An online election will take place in Spring 2020, and an electronic ballot will be administered. Only current AMA members with a valid email address on file in the AMA's system will be sent an email.

Requirements

The AMA-SPS Governing Council is responsible for directing the programs and activities of the section. Members' involvement includes meeting at the AMA House of Delegates Annual and Interim meetings (three days each) and one additional AMA-SPS Governing Council meeting (three days) in Chicago during July or August. There will also be various conference calls and regular mail communications. Further details forthcoming.

A full description of positions is located in the Internal Operating Procedures posted online on the AMA-SPS website (<http://ama-assn.org/senior-physicians-section>).

AMA-SPS nominations form

The nominee, nominating person or organization must complete an AMA-SPS nomination form by Feb. 29, 2020. Self-nominations will be accepted. Forms will be posted online (<http://ama-assn.org/senior-physicians-section>) in early January.





MEMBERSHIP
MOVES
MEDICINE™

The impact of vision and hearing loss in the senior population-

Why seeing and hearing are believing

2019 AMA Interim Meeting

**Noon – 1:30 p.m. | Saturday, November 16 | Grand Hall C
Manchester Grand Hyatt | San Diego, California
1.5 AMA PRA Category 1 Credits**

Program Description

The quality of life for seniors is often linked to hearing and vision loss which can be easily detected with simple testing. The majority of older people will experience some changes in their sensory capacity. However, most elderly patients are unwilling to consider the use of hearing aids, which has been shown to improve functional independence. This program will explore the links between age and sensory loss and ways to prevent its decline.

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 1.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



MEMBERSHIP
MOVES
MEDICINE™

Recruiting, Retaining, ‘Retraining,’ and Rewarding Community Physicians

2019 AMA Interim Meeting

**3 p.m. – 4 p.m. | Friday, November 15 | Harbor G
Manchester Grand Hyatt | San Diego, California
1.0 AMA PRA Category 1 Credits**

Program Description

Join fellow medical educators nationwide to learn strategies for recruiting, training, rewarding, and retaining community-based faculty for your medical students and residents. During this session, participants will learn tools and strategies to best engage community-based physicians in medical education. After a general presentation, the faculty will engage the audience in discussion of currently validated strategies as well as solicitation of new ideas and innovations.

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 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Speakers' Letter

2019 Interim Meeting of the AMA House of Delegates

November 16–19, 2019

Manchester Grand Hyatt – San Diego, California

Ladies and Gentlemen:

The following information is provided to aid your planning for the upcoming Interim Meeting in San Diego. **All attendees should be aware of the requirement to accept our AMA's policy on conduct at AMA meetings, and the procedures for delegates and alternate delegates are noted on page 2.** Also noted on that page is information on enhanced security for I-19. The online member forums are again available for this meeting, and we encourage you to promote the forums to your colleagues (see page 4 for details). The forums allow our membership to weigh in on policy matters, and use of the forums helps reference committees anticipate the issues that are likely to garner the most attention or concern.

Please call 312.464.4463, email hod@ama-assn.org or visit ama-assn.org/interim-meeting if you have questions regarding any of the following items or questions on American Medical Association policy. Watch the Interim Meeting website for updates to this *Speakers' Letter*.

Bruce A. Scott, MD, Speaker
Lisa Bohman Egbert, MD, Vice Speaker

House of Delegates schedule

The 2019 Interim Meeting of the AMA House of Delegates (HOD) will meet Nov. 16–19 at the Manchester Grand Hyatt in San Diego, California. The HOD will convene at 2 p.m. Saturday, Nov. 16 in the Seaport Ballroom. The Opening Session will conclude no later than 6 p.m. On Sunday, Nov. 17, the AMA-HOD will be in session from 8 to 8:30 a.m. to receive items of business, consider acceptance of late resolutions, and extract informational reports and items from the reaffirmation consent calendar. The following reference committees will convene open hearings from 8:30 a.m. to noon Sunday (room assignments subject to change):

Reference Committee on Amendments to Constitution & Bylaws	Grand Hall C
Reference Committee B (legislation)	Harbor Ballroom G–I
Reference Committee C (medical education)	Harbor Ballroom A–C
Reference Committee F (AMA governance and finance)	Seaport Ballroom
Reference Committee J (medical service, medical practice, insurance)	Harbor Ballroom D–F
Reference Committee K (science and public health)	Grand Hall D

Your Speakers believe that the likely number and nature of the medical education-related items warrants placing that business in a separate reference committee. This accords with past practice, as the business determines reference committee assignments.

The AMA-HOD will reconvene at 2 p.m. Monday, Nov. 18, and 8:30 a.m. Tuesday, Nov. 19 and will adjourn by noon on Tuesday. Your Speakers ask delegates to schedule departures no earlier than Tuesday afternoon so that they can fully consider the business debated that day.

Meeting details and reminders

Special Accommodations

Delegates and alternate delegates may request special accommodations (e.g., an assistive listening device) by contacting the Office of House of Delegates Affairs. Please call 312.464.4344 or send an email to hod@ama-assn.org so that arrangements can be made.

We have inquired about the availability of family and gender-neutral restrooms. California's Health and Safety Code specifies requirements for family / gender neutral restrooms that the Manchester Grand Hyatt's facilities do not satisfy. The Marriott does have one family restroom.

Handbook distribution

The initial Handbook will be posted on the Interim Meeting website by October 18. It will be posted as a single large document as well as in a series of smaller documents, collated by reference committee. The Addendum will be posted about October 25. When it is posted, the original Handbook and Addendum will be available separately along with a combined document that interleaves the Addendum with the Handbook. Like all other meeting materials, the Handbook will be posted at ama-assn.org/interim-meeting. An abridged Handbook containing only the recommendations from reports and the resolve clauses from resolutions will also be available as a Word document.

Registration

Registration for the AMA-HOD will be in the Palm Foyer, Seaport Tower, Second level. For security purposes, all attendees will be required to provide photo identification at the AMA registration desk to receive their credentials and other materials. Registration will be open from 10:30 a.m. to 7 p.m. Thursday, Nov. 14 and open at 7 a.m. from Friday through Tuesday.

Delegates and alternate delegates should check with their sponsoring society to ensure that their names have been submitted to the Office of House of Delegates Affairs prior to this meeting. AMA bylaws require that all delegates and alternate delegates be properly credentialed before *each* AMA-HOD meeting. Individuals whose credentials have not been confirmed prior to the Interim Meeting will have to be accompanied to the AMA registration desk by an officer of their society to register.

Delegates and alternate delegates for whom we have full contact information will find attached to printed copies of this *Speakers' Letter* a form that will implement Policy [G-600.032](#), "Delegate Credentialing and Expectations for Behavior," which the House adopted in June. **The form must be completed, signed and turned in to AMA registration staff at the Manchester Grand Hyatt to obtain credentials.** The form also allows delegates and alternate delegates to update the information that appears in the Pictorial Directory as well as to provide emergency contact information. Blank forms will be available in San Diego, but we encourage you to complete the form in advance to facilitate your onsite registration. Readers of the online *Speakers' Letter* should print the form, complete it and bring it to San Diego.

Individuals other than delegates and alternate delegates who attend the Interim Meeting should register online by visiting the interim meeting [website](#). All attendees, including guests, are required to acknowledge and accept Policy [H-140.837](#), "Policy on Conduct at AMA Meetings and Events." Those not registered in advance will have to complete their acknowledgement onsite before receiving a badge. A badge will be required to attend all functions.

Meeting security

Attendees will see increased security at the Interim Meeting, starting with name badges. Not only are the badges being changed, but those not wearing their badges in and around the House may expect to be asked to display their badge. While your badge will be needed inside the meeting venue, don't forget to remove it when you leave the facility. Additional security enhancements will also be apparent in and around the meeting venue.

Recording of AMA-HOD meetings

AMA meetings may be recorded by audiotape, videotape or otherwise, for use by the AMA. Participation in or attendance at a meeting shall be deemed to confirm the participant's consent to recording and to the AMA's use of such recording.

Code of conduct

Referenced above (page 2) is our AMA's code of conduct, which was designed to ensure a professional and welcoming environment for all attendees at AMA-sponsored meetings. Importantly, everyone should feel safe and able to participate without fear of unwelcome conduct, whether in face-to-face contacts or electronic communications. Attendees should declare conflicts of interest and conduct themselves in a manner that is attune to the highest ideals of the profession. The policy can be accessed at ama-assn.org/codeofconduct. Harassment and conflicts of interest are serious, and House policy provides for reporting and dealing with both matters.

Our standing rules, which are ratified in the opening session, commit each of us to be courteous, respectful and collegial in the conduct of HOD business. Instances of unwelcome or inappropriate behavior should be brought to the attention of your Speakers or the conduct liaison, and everyone has the personal responsibility, while engaging with others, to consider how others will interpret their actions and words.

Meeting attire

Your Speakers have determined that business casual attire is appropriate for the Interim Meeting, except when individuals are on the dais, at which time business attire is requested. This would include the presentation of reference committee reports or any other report given from the dais.

Childcare services

Childcare will be available from 7 a.m. to 7 p.m. Thursday, Nov. 14 through Monday, Nov. 18 and from 7 a.m. to noon on Tuesday, Nov. 19. Registration is available through the [vendor](#) or the meeting [website](#). Reservations are required to ensure space, but walk-ins will be accepted when possible. Fees are somewhat lower than they have been:

	<u>6 months to 35 months</u>	<u>Age 3 years to 17 years</u>
Half day (7 a.m. to 1 p.m. or 1 p.m. to 7 p.m.)	\$50	\$40
Full day (7 a.m. to 7 p.m.)	\$80	\$70
Tuesday (7 a.m. to noon)	\$45	\$40
Hourly rate, 4 hour minimum	\$12/hr	\$10/hr

There is a \$10 non-refundable administrative fee per child. The vendor, Accent on Children, is fully licensed, and caregivers have considerable experience in working with children. Meals are available separately for \$15, but meals will not be available for purchase onsite through Accent.

Nursing mothers

A location will be available for nursing mothers who wish to express milk or nurse their infants. Interested mothers should contact the AMA Headquarters Office.

Travel discounts

A discount is available on United Airlines and may be accessed through the meeting website or obtained online at [united.com](#).

- Click on "Advanced search"
- Enter origin, destination, and travel dates
- Enter Offer Code ZGE5912085 in the "Promotions and Certificate" box

When an available flight is selected, the discounted fare will automatically be calculated. The discount is valid for travel 3 days prior to and 3 days after the official meeting dates. A discount may also be obtained by calling United Airlines Meetings at 800.426.1122 and mentioning Z code ZGE5 and Agreement code 912085. A service fee will apply to telephone bookings.

Distribution of non-business items

Material received in the production area of the Headquarters Office at the hotel by 5 p.m. Thursday, Nov. 14, will be collected in a bag and placed on delegates' tables and on chairs before the House opens on Saturday. Thirteen hundred (1300) copies are required for a complete distribution throughout the House. When you arrive in San Diego, we suggest that you check with AMA staff in the production area to ensure that your materials were received. Mailing information to ensure proper delivery was included with the meeting information memo (available [online](#)).

Opening Session agenda

The Opening Session will get underway at 2 p.m. Saturday, Nov. 16 in the Seaport Ballroom. Included in the Opening Session will be the presentation of various awards and addresses by AMA President Patrice Harris, MD, and Executive Vice President James Madara, MD. The session will conclude by 6 p.m.

Nomination and election of new public member of the Board of Trustees

As we go to print, the nomination of the new public member of the Board of Trustees is also expected during the Opening Session, with the election taking place either Saturday afternoon or Sunday morning, depending on when the candidate's conflict of interest disclosure is posted to the AMA website.

Although the new public member will be elected in San Diego, the current public member, Kevin Williams, serves until the close of the next Annual Meeting. The early election of his successor is supported in our bylaws and allows the new public member to gain exposure to the Board's operations before taking office.

Meeting app

Our AMA's mobile app will again be available for the Interim Meeting to help attendees connect and network with peers. Use the app during the meeting for comprehensive information about activities and events. As in June the app will allow users to integrate the meeting schedule with their mobile device calendar, create session notes and appointments, and access interactive maps of the hotel, which will provide event locations. Important meeting updates will also be provided through the notification tools in the app.

Users should download the "AMA 2019 Interim Meeting" app from their app store. Search for CrowdCompass AttendeeHub. Once there, search "AMA" and tap on the 2019 AMA Interim Meeting. The app launches about October 28.

Online member forums

As mentioned in the meeting information memo, each reference committee includes an online member forum. The forums can be accessed directly at ama-assn.org/forums/house-delegates or via the meeting website. Items will be added over time, so we suggest that you check back occasionally. Instructions are found on the site. Questions about the forum can be sent to hod@ama-assn.org or to roger.brown@ama-assn.org.

The forums will remain open for commenting up to the opening of the House, but comments posted after Sunday, Nov. 10 are unlikely to be captured in the summary reports that are prepared and posted on the meeting [website](#).

PolicyFinder

The latest edition of PolicyFinder is available at policysearch.ama-assn.org. The current version is complete through the 2019 Annual Meeting.

Proceedings of the 2019 Annual Meeting

The *Proceedings* of the House of Delegates for the 2019 Annual Meeting (A-19) have been posted on the AMA website. Approval of the minutes from A-19 is an action item at the Sunday morning session of the AMA-HOD. Corrections should be sent to hod@ama-assn.org.

Conflict-of-interest policy

Sponsors of resolutions are reminded that the AMA-HOD has established policy ([G-600.060](#)) calling on delegates introducing an item of business for consideration by the AMA-HOD to declare any commercial or financial conflict of interest at the time the resolution is submitted and that any such conflict of interest be included with the resolution.

Your Speakers have determined that this policy also applies to resolutions introduced by delegations. The sponsoring delegation must disclose the identity of any delegate or alternate delegate who has a commercial or financial interest with respect to matters addressed in the resolution. If a conflict is disclosed, the notation on the resolution will not contain an individual delegate's name, but will state in substance that, "In accordance with House policy regarding disclosure of conflicts of interest, the delegation has notified the Speaker that one or more delegates has a commercial or financial conflict of interest with respect to the matters addressed in this resolution." For resolutions already submitted, please notify the AMA Office of House of Delegates Affairs. A revised resolution containing the conflict-of-interest statement will be distributed.

HOD Reference Manual: Procedures, Policies and Practices

The HOD Reference Manual describes House procedures. Available online, it may be accessed through the meeting [website](#). The manual may be especially helpful to new delegates, but it is also a good reference for experienced delegates, Federation staff and other meeting participants. The House will be asked to adopt the updated reference manual as the official method of procedure in handling and conducting the business as part of the rules report at the opening session.

Announcements for 2020 elections

Individuals who intend to seek election at the 2020 Annual Meeting are reminded that printed announcements may not be distributed in the meeting venue. Announcements provided to us by noon, Sunday, Nov. 17 will be projected on the last day of the meeting. An electronic announcement should be submitted to Roger Brown (roger.brown@ama-assn.org) in the Speakers' Office; the preferred format is JPG, but a PDF or PowerPoint slide (16:9 format) is also acceptable. Submissions will be maintained in confidence until posted. Announcements will be posted [online](#) after the meeting.

Meetings and caucuses**OSMAP**

The Organization of State Medical Association Presidents (OSMAP) will hold its semi-annual membership meeting and general session from 2 to 5 p.m. Friday, Nov. 15 in Harbor Ballroom A-B. All state medical association presidents, presidents-elect, past presidents and executive directors are welcome and encouraged to attend. An agenda and related meeting materials will be posted on the OSMAP web site (osmapandtheforum.org) prior to the meeting.

If you have any topics you would like submitted for the agenda, please contact Brian O. Foy, OSMAP Executive Director, at bfoy11@yahoo.com. Immediately following the general session, OSMAP will host a reception in Harbor Ballroom D-F. All OSMAP members and their invited guests are welcome to attend.

Surgical Caucus Handbook review

The Surgical Caucus of the AMA will meet from 7 to 9:30 a.m. Saturday, Nov. 16 in Coronado E for a combined business meeting/handbook review session; breakfast will be available at 6:45 a.m. Specialties in the Caucus are encouraged to send at least one representative to this meeting.

Rural Health Caucus

Residents of rural areas have been shown to be generally sicker, poorer, and older than their counterparts in urban areas. Recent research shows that women do not have access to obstetric care in 54% of rural counties. These issues are further compounded by health care workforce shortages and decreased resource availability.

The challenges that rural patients and those who care for them face result in unique perspectives on the practice of medicine.

All AMA meeting attendees, including delegates and alternate delegates, representatives of state or specialty societies, medical students, residents, section leaders, AMA staff, and Board members are invited to attend the Rural Medicine Caucus policy discussion at 1 p.m. Sunday, Nov. 17 in Regatta. Attendees will enjoy networking with colleagues, sharing ideas on how the AMA might better serve rural physicians and patients, and discussing any resolutions that attendees feel are applicable to practice in rural or other low-resource settings. Please contact Jordan Warchol, MD, at JordanWarcholMD@gmail.com for more information.

Election task force open forum

In lieu of our usual speaker-to-speaker meeting on Sunday afternoon, the election task force that was approved in June will hold an open forum to hear suggestions and discuss options for improving our election processes. The task force will submit an initial report in San Diego as called for by Policy [G-610.031](#). This report will provide a framework for the discussion but will not include their final recommendations. Comments or suggestions may be sent to hod@ama-assn.org for consideration by the task force.

The forum will be styled like and follow the reference committee hearings. It will begin at 1 p.m. and run as long as necessary in Grand Hall D.

Obesity Caucus

The Obesity Caucus will meet from 5 to 6 p.m. Sunday, Nov. 17 in Balboa. This is an open caucus, so all are welcome. Suggested agenda items should be sent to caucus chair, Ethan Lazarus at ethanlazarus@gmail.com.

Private Practice Physician's Congress

The Private Practice Physician Congress will meet at 11:30 a.m. Monday, Nov. 18 in Harbor Ballroom A-B. All AMA members interested in the private practice of medicine, including young physicians, residents, fellows and medical students, are invited to join the meeting. The group includes primary care and specialty care physicians.

For questions or comments please contact Zuhdi Jasser, MD, Chair, at zuhdi@jasserm.com or 602.721.7186; Tim McAvoy, MD, Vice-chair, at timothymcavoy@yahoo.com or 414.573.0751; or Barb Hummel, MD, Secretary, at hummel@ameritech.net or 414.690.6352.

Educational programming

Several education programs will be offered during the Interim Meeting. All members are welcome to attend any of the education sessions listed below, many of which are sponsored by the sections and special groups. These sessions will be offered between Thursday, Nov. 14 and Monday, Nov. 18. Many sessions will be sponsored by the AMA sections, although details for many remain to be worked out.

Education sessions designated by the AMA for CME credit are indicated by an asterisk (*).

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates each live activity for the maximum number of *AMA PRA Category 1 Credits™* reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The deadline to claim credit for sessions certified by the AMA is December 31, 2019. To claim credit, access the session on the meeting mobile app or visit the AMA Ed Hub™ at edhub.ama-assn.org. For help in claiming credit or printing certificates, visit the AMA Ed Hub booth. You may also contact the AMA Unified Service Center at 800.262.3211 for assistance.

Sessions certified for credit by other CME providers are indicated with a dagger (†), but those sessions are not available via the AMA Ed Hub. Sessions that will be held at the Marriott are so noted; all other sessions are at the Manchester Grand Hyatt.

You thought you only had a duty of care to your patients? - Minnesota's Warren v. Dinter decision

1:30–2 p.m. Thursday, Nov. 14, Marina D (Marriott)

Hosted by the AMA Organized Medical Staff Section

Managing gender bias in medical careers

8–8:45 a.m. Friday, Nov. 15, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Adverse childhood experiences and trauma informed care for migrant populations and displaced peoples

8:30–9:15 a.m. Friday, Nov. 15, Coronado (Marriott)

Hosted by the AMA Medical Student Section

No street left behind: How integrated systems affect social determinants of health

8:30 a.m.–noon Friday, Nov. 15, Marina E (Marriott)

Hosted by the AMA Integrated Physician Practice Section

La Frontera—The unknown frontier of women's health care at the US-Mexico border

9–9:45 a.m. Friday, Nov. 15, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Peer review survival kit: Is your peer review process safe?

9:15–10:15 a.m. Friday, Nov. 15, Marina D (Marriott)

Hosted by the AMA Organized Medical Staff Section

Family detention in US immigration: The interface of medical ethics and advocacy

Noon–1:15 p.m. Friday, Nov. 15, Marina F (Marriott)

Hosted by the AMA Young Physicians Section

The AMA policymaking lifecycle: Turning ideas into policy and then into solutions!

12:30–1:15 p.m. Friday, Nov. 15, Marina D (Marriott)

Hosted by the AMA Organized Medical Staff Section

Professionalism on social media, and its uses in networking, advocacy, and professional development

1–1:45 p.m. Friday, Nov. 15, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Employer-driven innovations: Reshaping health care delivery

1–2:30 p.m. Friday, Nov. 15, Marina E (Marriott)

Hosted by the AMA Integrated Physician Practice Section

I am human: A look at shortcomings in the United States prison health care system

1:30–2:15 p.m. Friday, Nov. 15, Coronado (Marriott)

Hosted by the AMA Medical Student Section

The credentialing, privileging, and enrollment processes: How what you don't know can hurt you!

1:30–2:30 p.m. Friday, Nov. 15, Marina D (Marriott)

Hosted by the AMA Organized Medical Staff Section

The promise of Project ECHO as an educational paradigm

1:45–2:45 p.m. Friday, Nov. 15, Grand Hall D

Hosted by the AMA Academic Physicians Section

Seeking mental health care as physicians and future physicians

2–3 p.m. Friday, Nov. 15, Marina G (Marriott)

Hosted by the AMA Medical Student Section

Structural violence—Understanding the bias against patients with a history of substance abuse

2:30–3:15 p.m. Friday, Nov. 15, Coronado (Marriott)

Hosted by the AMA Medical Student Section

Demystifying employment contracts

2:45–3:45 p.m. Friday, Nov. 15, Marina D (Marriott)

Hosted by the AMA Organized Medical Staff Section

Cultural humility and implicit bias: Moving toward equitable health care

3–3:45 p.m. Friday, Nov. 15, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Recruiting, retaining, retraining, and rewarding community physicians

3–4 p.m. Friday, Nov. 15, Grand Hall D

Co-hosted by AMA Academic Physicians Section and the AMA Senior Physicians Section

Unraveling the mysteries of surprise billing

3:30–4:15 p.m. Friday, Nov. 15, Coronado (Marriott)

Hosted by the AMA Medical Student Section

Healthcare think tank: Members Moving Medicine

4–5 p.m. Friday, Nov. 15, La Costa (Marriott)

Hosted by the AMA Medical Student Section

US health care reform—Diving into economic, physician, and patient aspects of proposed health care

8–8:45 a.m. Saturday, Nov. 16, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Developing sustainable global health projects in the age of voluntourism

8:30–9:15 a.m. Saturday, Nov. 16, Coronado (Marriott)

Hosted by the AMA Medical Student Section

Amplify your voice: How physicians can shape health policy

9–9:45 a.m. Saturday, Nov. 16, Harbor Ballroom G-H

Hosted by all AMA Sections and Advisory Committee

Identifying clinical problems and driving needs-oriented innovation in medicine

9–9:45 a.m. Saturday, Nov. 16, La Costa (Marriott)

Hosted by the AMA Medical Student Section

Using cost-effectiveness to determine coverage priorities

9:30–10:15 a.m. Saturday, Nov. 16, Coronado (Marriott)

Hosted by the AMA Medical Student Section

The new MOC: Continuing board certification

9:45–11 a.m. Saturday, Nov. 16, Grand Hall D

Co-hosted by the AMA Academic Physicians Section, the AMA Young Physicians Section, and the AMA Council on Medical Education

Telemedicine and mobile apps—accessing birth control without stepping foot in a clinic

10–10:45 a.m. Saturday, Nov. 16, La Costa (Marriott)

Hosted by the AMA Medical Student Section

The impact of vision and hearing loss in the senior population—Why seeing and hearing are believing

Noon–1:30 p.m. Saturday, Nov. 16, Grand Hall C

Hosted by the AMA Senior Physicians Section

Fair market pricing for prescription drugs

5:15–6 p.m. Saturday, Nov. 16, Harbor Ballroom B

Hosted by the AMA International Medical Graduates Section

Investigating gender bias in medical student evaluations

6–6:30 p.m. Saturday, Nov. 16, Harbor Ballroom A

Hosted by the AMA Women Physicians Section

Health Impact of Climate Change - Preparing Your Communities and Practices

1–3:30 p.m. Sunday, Nov. 17, Harbor Ballroom A-B

Hosted by the Forum for Medical Affairs

This program will feature three prominent speakers in the field of climate change and health. Nitin S. Damle, MD, Clinical Associate Professor of Medicine, Alpert Medical School of Brown University, and ACP Delegate, will kick off with “Climate Change and Health: The Greatest Health Threat and Opportunity of the 21st Century.” Next, Mona Emily Senay, MD, MPH, Assistant Professor of Medicine, Department of Environmental Medicine and Public Health, Icahn School of Medicine at Mount Sinai (NY), will present “Healthcare Delivery and the Climate Crisis.” Following will be Mona Sarfaty, MD, Executive Director, Medical Society Consortium on Climate and Health, Center for Climate Change Communication, who will present “What Physicians Can Do About Climate Change.” A panel discussion will follow with Q&A. The program will be moderated by Steven P. Kanig, MD, Forum President.

Attendees will learn about: 1) the science behind the effects of climate change; 2) the seven health effects of climate change; and 3) what physicians can do to prepare for and respond to these new challenges.

All members of the AMA House of Delegates, their spouses and invited guests, and staff are welcome to attend. There is no cost to attend, and pre-registration is not required. For more information regarding The Forum, please go to osmapandtheforum.org.

***Training Physicians in the Art of the Public Forum (1.5 AMA PRA Category I Credits™)**2–3:30 p.m. Sunday, Nov. 17, City View [32nd floor] (also offered 8 a.m. Monday)

Hosted by AMA Enterprise Communications

Whether you’re preparing to deliver a keynote presentation at a high-profile medical conference or talking with a reporter from your hometown newspaper, the ability to support your position with clear and concise language and relevant points is paramount. These sessions are designed to help physicians at all levels better prepare for public speaking opportunities and media interviews through skilled and confident communication. Participants will learn best practices for effective communication, including how the AMA trains its leaders to carry the message of the organization to diverse audiences. Industry leaders and AMA communications staff will share tips and engage participants in role-playing exercises to help them stay on message and effectively connect with diverse audiences about health care issues and policies that are important to physicians, their patients and their practices.

Following these sessions, attendees will have the opportunity to become AMA Ambassadors and further their learning around public engagement. The trainings will be led by Kathy Schaeffer, a strategic

communications expert, in partnership with leaders from the AMA's Enterprise Communications department. Attendees are asked to RSVP ahead of the sessions to tamara.washington@ama-assn.org.

Litigation Center Open Meeting

2–4 p.m. Sunday, Nov. 17, Harbor Ballroom D-F

Hosted by the Litigation Center of the American Medical Association and State Medical Societies

The Litigation Center Open Meeting will feature as its principal presentation a moot court argument based on a recent Minnesota Supreme Court case, which found that an internist could be professionally liable to someone who was not his patient and whom he had never met. A discussion will follow about how this holding could affect individual physician practices.

AMA Ambassador Training Sessions

2–2:45 p.m. Sunday, Nov. 17, America's Cup A-B

Are you new to the AMA Ambassador Program? This onboarding session will allow you to hit the ground running as an AMA Ambassador.

3–4 p.m. Sunday, Nov. 17, America's Cup A-B

Your personal and professional brand is everything! During this session, Dr. Tyeese Gaines of Doctor Ty Media, will share the best practices for physicians and AMA Ambassadors as they build a brand, cultivate followers and create their niche.

3–4 p.m. Sunday, Nov. 17, America's Cup C-D

Being an ambassador on social media is more than just amplifying news, it's also about effectively responding and engaging in conversation. Join us for a breakout session where we'll dig into case studies, both positive and negative, and workshop how best to respond in each scenario.

4–5 p.m. Sunday, Nov. 17, America's Cup A-B

What do you say when colleagues ask, "Why are you an AMA member?" Or when colleagues ask, "what exactly does the AMA do?" In this session, you will hone your Ambassador skills and perfect your elevator pitch. First you will hear from a couple AMA experts and seasoned Ambassadors and then you will practice your elevator pitch as well as provide constructive feedback to others.

4–5 p.m., Sunday, Nov. 17, America's Cup C-D

Whether you're new to the program or simply need a refresher, join us for a deep dive on how to use the AMA's activation hub, Smarp. As an ambassador, consider Smarp your digital "pantry" where you can find content to easily share to your social media channels. Or if you're still feeling unsure about social media in general, stop by during this time to chat with AMA social media staff about any specific questions or concerns you may have.

Back to basics: The fundamentals of extraordinary leadership

2:30–3:30 p.m. Sunday, Nov. 17, Coronado D

Hosted by the AMA International Medical Graduates Section

AMPAC Presents an Insiders "How to" Guide to Running and Winning a Campaign

3–4 p.m. Sunday, Nov. 17, ~~Cortez A/B Grand Hall C~~

Hosted by AMPAC

Have you ever wondered how doctors get elected to public office? Have you considered a run for office yourself? Join us for an in-depth preview of AMPAC's annual "Candidate Workshop" political education program. Led by Eva Pusateri, lead consultant and trainer for the AMPAC Candidate Workshop, in this session you will learn how the intensive two-day Candidate Workshop will prepare you with the tools you need to run a winning political campaign. The program is designed to help you make the leap from the exam room to campaign trail and give you the strategic advantage you will need to make your run for public office.

Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021

3–4:30 p.m. Sunday, Nov. 17, Harbor Ballroom G-I

Hosted by the CPT/RUC Workgroup on Evaluation and Management

The Co-Chairs of the CPT/RUC Workgroup on Evaluation and Management (E/M) will describe the new CPT framework for reporting office visits. On Nov. 1, CMS announced that Medicare will implement these changes on January 1, 2021. Physicians will no longer be required to engage in unnecessary and burdensome documentation to report office visits. The new framework will provide physicians with reporting by either total time spent on the date of the visit or the medical decision-making used in the provision of the service. Doctors Peter Hollmann and Barbara Levy will also explain the AMA/Specialty Society RVS Update Committee's recommendations to increase the valuation of office visits.

***Training Physicians in the Art of the Public Forum (1.5 AMA PRA Category I Credits™)**8–9:30 a.m. Monday, Nov. 18, ~~La Jolla Grand Hall D~~ (also offered 2 p.m. Sunday)

Hosted by AMA Enterprise Communications

Whether you're preparing to deliver a keynote presentation at a high-profile medical conference or talking with a reporter from your hometown newspaper, the ability to support your position with clear and concise language and relevant points is paramount. These sessions are designed to help physicians at all levels better prepare for public speaking opportunities and media interviews through skilled and confident communication. Participants will learn best practices for effective communication, including how the AMA trains its leaders to carry the message of the organization to diverse audiences. Industry leaders and AMA communications staff will share tips and engage participants in role-playing exercises to help them stay on message and effectively connect with diverse audiences about health care issues and policies that are important to physicians, their patients and their practices.

Following these sessions, attendees will have the opportunity to become AMA Ambassadors and further their learning around public engagement. The trainings will be led by Kathy Schaeffer, a strategic communications expert, in partnership with leaders from the AMA's Enterprise Communications department. Attendees are asked to RSVP ahead of the sessions to tamara.washington@ama-assn.org.

***CEJA Open Forum - Identifying Gaps in the *Code of Medical Ethics* (1.5 AMA PRA Category I Credits™)**

9:30–11 a.m. Monday, Nov. 18, Grand Hall C

Hosted by the Council on Ethical and Judicial Affairs

The Open Forum will be open to all AMA members, interested non-members, other guests, and the press and will have three parts. Parts one and two will consist of participants identifying and discussing potential gaps in the *Code of Medical Ethics* within given chapters. The sections covered will be:

- [Chapter 9, Section 7: Interaction with government agencies](#) (35 minutes)
- [Chapter 10: Interprofessional Relationships](#) (35 minutes)

Each topic will be introduced by a member of CEJA and followed by a group discussion. Although participants will have time during the session to review the identified content, it may be helpful to review the links above beforehand. This exercise will mimic the types of questions, considerations and framing that go into a CEJA discussion of gaps in the *Code*. Questions for discussion will include:

- Is new ethics guidance needed in this domain? If so, what do you consider the most urgent issue to address?
- How do you see new ethics guidance on the issue fitting into this chapter?
- How do you feel new ethics guidance would
 - Promote patients' interests?
 - Support physicians?
- What implications (if any) do you feel new ethics guidance would have for health care organizations?
- Who do you see as key stakeholders on the issue?

In the third part of the session, attendees are invited to introduce other issues that may warrant attention from CEJA and inclusion in the *Code of Medical Ethics*.

Upon completion of this session, participants will be able to:

- Describe CEJA's approach to identifying topics for new guidance within the *Code of Medical Ethics*
- Explain the nature and scope of CEJA's role in developing ethics policy
- Recognize the challenges of crafting policy in a way which addresses the positions of various stakeholders

President's panel: Physicians' obligation to lead

9:30–11 a.m. Monday, Nov. 18, Harbor Ballroom C

Hosted by our AMA

In this session, you will gain a better understanding of the role of the AMA and its physician members in advocacy and activism in issues related to immigration, women's health, LGBTQ health, gun violence and health equity. AMA's General Counsel will share several AMA litigation examples that demonstrate AMA policies and directives in action. Additionally, a historical perspective on medicine, activism, and socio-political change will be discussed.

The session will be moderated by AMA President Patrice A. Harris, MD, MA, and include a presentation from Brian Vandenberg, JD, AMA's General Counsel, along with a reactor panel made up of AMA Board Chair Jesse Ehrenfeld, MD, MPH; Rodney Hood, MD, past-president, NMA; Aletha Maybank, MD, MPH, AMA's chief health equity officer; and Dalia G. Larios Chavez, MD, a resident at Brigham & Women Hospital.

If you have questions, email J. Mori Johnson at jmori.johnson@ama-assn.org.

Council on Legislation Forum

The Council on Legislation (COL) will hold a one-hour forum from 9 to 10 a.m. Monday, Nov. 18, in Harbor Ballroom DEF.

Hear from the COL's executive committee how our AMA is working to protect the interests of physicians and our patients through its federal and state advocacy efforts. The forum is also intended to provide HOD attendees the opportunity to share with the Council and others their comments on emerging federal and state legislative and regulatory issues impacting patients and the practice of medicine.

†Is there a doctor on board? – Dealing with in-flight emergencies

10–11 a.m. Monday, Nov. 18, Grand Hall D

Hosted by the Surgical Caucus of the AMA

This session will identify the most common in-flight medical emergencies; describe in-flight resources available for responding to a medical emergency; and discuss the legal ramifications of providing care for an in-flight medical emergency.

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Section and Special Group Events

The AMA Section Meetings will be held Nov. 14-16 at the Manchester Grand Hyatt and Marriott Marquis. Visit each section's meeting page for agendas and other meeting documents, and for the most up-to date-information, please refer to the [AMA meeting app](#).

- [Academic Physicians Section](#) (APS)
Nov. 15-16, Manchester Grand Hyatt
- [Advisory Committee on LGBTQ Issues](#) (LGBTQ)
Nov. 15, Manchester Grand Hyatt
- [Integrated Physician Practice Section](#) (IPPS)
Nov. 15, Marriott Marquis
- [International Medical Graduates Section](#) (IMGS)
Nov. 16, Manchester Grand Hyatt
- [Medical Student Section](#) (MSS)
Nov. 14-16, Marriott Marquis
- [Minority Affairs Section](#) (MAS)
Nov. 15-16, Manchester Grand Hyatt
- [Organized Medical Staff Section](#) (OMSS)
Nov. 14-15, Marriott Marquis
- [Resident and Fellows Section](#) (RFS)
Nov. 14-16, Marriott Marquis
- [Senior Physicians Section](#) (SPS)
Nov. 16, Manchester Grand Hyatt
- [Women Physicians Section](#) (WPS)
Nov. 16-17, Manchester Grand Hyatt
- [Young Physicians Section](#) (YPS)
Nov. 14-15, Marriott Marquis

Exhibits

AMA Foundation Booth

Visit the [AMA Foundation](#) booth to learn how the Foundation is improving the nation's health through its *Community Health Programs* and encouraging future physician leaders through the *Physicians of Tomorrow Scholarships* and *Leadership Development Institute*. While you're there, make sure to check out the collectible 2019 San Diego Meeting pin. Don't have time to stop by the booth? Visit online at [amafoundation.org](#) or in the AMA Meetings app.

For additional information, please call 312.464.4200 or email amafoundation@ama-assn.org.

Visit the Member Center Booth and pick up a gift!

Located between Registration and the Terrace be sure to visit the Member Center between Saturday, Nov. 16 and Tuesday, Nov. 19.

- Get assistance with membership related inquiries
- Update your AMA account to customize your news subscriptions
- Pick up a free gift
- And check out a few new surprises

Special events

AMA EXPO

Be sure to visit the AMA Expo from 1 to 6 p.m. Friday, Nov. 15 in Grand Hall C-D. The Expo will include several components:

- AMA Career Fair – Connect with recruiters to learn more about residency programs and health care institutions of varying sizes.
- AMA Group Member exhibitors – Here's the chance to market the organization to both residents and young physicians seeking career opportunities within a medical group or health system.
- AMA Research Symposium – Share your expertise and view original research from students, residents, fellows and international medical graduates.
 - The poster showcase will run from 3 to 6 p.m.
 - The poster competition will take place from 4 to 6 p.m.

Find more information about the AMA EXPO at ama-assn.org/events/ama-expo.

AMA Ambassadors lounge

Are you a proud and loyal AMA member? Are you excited to share the value of an AMA membership with your colleagues? If you answered “yes”, stop by the Ambassadors Lounge in the Seaport Ballroom Foyer at the Hyatt to recharge and learn more about our AMA’s newest Member Experience program.

Ambassadors lounge activities will allow you to:

- Pick-up Ambassador gifts
- Submit your Ambassador update
- Sign-up for Ambassador Training Sessions
- Network with other AMA Ambassadors and “recharge”
- Learn about the Ambassador activation app

Hours for the lounge are:

- 1–5 p.m. Friday, Nov. 15
- 9 a.m.–5 p.m. Saturday, Nov. 16
- 7:30 a.m.–5 p.m. Sunday, Nov. 17
- 9 a.m.–5 p.m. Monday, Nov. 18
- 8–11:30 a.m. Tuesday, Nov. 19

Questions may be emailed to [J. Mori Johnson](mailto:J.Mori.Johnson@ama-assn.org) or visit ama-assn.org/ambassadors for more information and to enroll in the AMA Ambassador Program.

Free hearing tests

8–10 a.m. Saturday, Nov. 16, Mission Hills (Marriott)

Hosted by the AMA Senior Physicians Section and the American Academy of Otolaryngology-Head and Neck Surgery.

Advance registration is required by visiting surveymonkey.com/r/D5DGCQ3, and tests are available on a first-come, first-served basis.

Catholic Mass

Catholic Mass will be celebrated at 6:30 p.m. Saturday, Nov. 16 in Grand Hall C. **The celebrant will be Fr. Gilbert Gentile, SJ.**

Welcome to California Mixer!

The California Medical Association and the California Delegation to the AMA would like to invite you to a Welcome to California Mixer on the flight deck of the USS Midway (910 N. Harbor Drive). The event will be held from 6:30 to 10:30 p.m. Sunday, Nov. 17. There is no cost to attend and a complimentary shuttle will be running from the Manchester Grand Hyatt to the USS Midway. Come and enjoy heavy hors d'oeuvres, libations, and dancing on the historic USS Midway. Please make sure to wear comfortable shoes and bring a coat as it can get a little cold on the flight deck in November!

AMPAC Capitol Club luncheon

The American Medical Association Political Action Committee (AMPAC) is the bipartisan political arm of the AMA that helps elect medicine-friendly candidates running for federal office. AMPAC needs your support to have an impact on the AMA's continuing advocacy efforts in Washington, DC.

AMPAC will be hosting a private luncheon for all 2019 Capitol Club members from noon to 1:30 p.m. Monday, Nov. 18. AMPAC's special guest will be Stephen Fried, award winning journalist and New York Times best-selling author. Mr. Fried will be discussing his latest work, George Washington Book Prize finalist, *Rush*, the story of Benjamin Rush, a visionary physician and political thinker who was advisor to, and caretaker of America's first leaders. Rush served as Surgeon General of the Continental Army and as personal physician to Benjamin Franklin, George Washington, John Adams, and Thomas Jefferson; was one of the youngest signatories of the Declaration of Independence; and is one of our most provocative and unsung Founding Fathers, largely forgotten, until now. This is an event you don't want to miss!

If you are already a 2019 AMPAC Capitol Club member, please stop by the AMPAC booth to pick up your ticket to join us for this exciting discussion. As a reminder, 2019 Capitol Club Platinum members can attend an exclusive private meet and greet with Mr. Fried prior to the start of the luncheon.

If you are interested in becoming an AMPAC member or would like more information on the luncheon you can speak with an AMPAC staff member at our booth located outside of the House of Delegates meeting room from Friday, Nov. 16 through Tuesday, Nov. 19.

NOTES



The following list is provided for your convenience. All items mentioned in the *Speakers' Letter* are included along with a few other items of possible interest.

(Items listed in bold are official AMA-HOD sessions, reference committees or programs.)

Events are at the Manchester Grand Hyatt unless italicized.

Activities offering continuing medical education credit are preceded by an asterisk (*) or dagger (†).

Time	Event	Location†
Thursday, November 14		
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
10:30 a.m.–7 p.m.	Delegate registration	Palm Foyer, Seaport Tower
<i>1:30–2 p.m.</i>	<i>You thought you only had a duty of care to your patients?</i>	<i>Marina D (Marriott)</i>
5 p.m.	Deadline for not for official business bag	AMA production area at Manchester Grand Hyatt
Friday, November 15		
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
<i>8–8:45 a.m.</i>	<i>Managing gender bias in medical careers</i>	<i>La Costa (Marriott)</i>
<i>8:30–9:15 a.m.</i>	<i>Adverse childhood experiences and trauma informed care for migrant populations and displaced peoples</i>	<i>Coronado (Marriott)</i>
<i>8:30 a.m.–noon</i>	<i>No street left behind: How integrated systems affect social determinants of health</i>	<i>Marina E (Marriott)</i>
<i>9–9:45 a.m.</i>	<i>La Frontera—The unknown frontier of women's health care at the US-Mexico border</i>	<i>La Costa (Marriott)</i>
<i>9:15–10:15 a.m.</i>	<i>Peer review survival kit: Is your peer review process safe?</i>	<i>Marina D (Marriott)</i>
<i>Noon–1:15 p.m.</i>	<i>Family detention in US immigration: The interface of medical ethics and advocacy</i>	<i>Marina F (Marriott)</i>
<i>12:30–1:15 p.m.</i>	<i>The AMA policymaking lifecycle: Turning ideas into policy and then into solutions!</i>	<i>Marina D (Marriott)</i>
<i>1–1:45 p.m.</i>	<i>Professionalism on social media, and its uses in networking, advocacy, and professional development</i>	<i>La Costa (Marriott)</i>
<i>1–2:30 p.m.</i>	<i>Employer-driven innovations: Reshaping health care delivery</i>	<i>Marina E (Marriott)</i>
<i>1–5 p.m.</i>	AMA Ambassadors lounge	Seaport Ballroom Foyer
<i>1–6 p.m.</i>	AMA Expo	Grand Hall C-D
<i>1:30–2:15 p.m.</i>	<i>I am human: A look at shortcomings in the United States prison health care system</i>	<i>Coronado (Marriott)</i>
<i>1:30–2:30 p.m.</i>	<i>The credentialing, privileging, and enrollment processes: How what you don't know can hurt you!</i>	<i>Marina D (Marriott)</i>
<i>1:45–2:45 p.m.</i>	<i>The promise of Project ECHO as an educational paradigm</i>	Grand Hall D
<i>2–3 p.m.</i>	<i>Seeking mental health care as physicians and future physicians</i>	<i>Marina G (Marriott)</i>
<i>2–5 p.m.</i>	OSMAP	Harbor Ballroom A-B
<i>2:30–3:15 p.m.</i>	<i>Structural violence—Understanding the bias against patients with a history of substance abuse</i>	<i>Coronado (Marriott)</i>
<i>2:45–3:45 p.m.</i>	<i>Demystifying employment contracts</i>	<i>Marina D (Marriott)</i>
<i>3–3:45 p.m.</i>	<i>Cultural humility and implicit bias: Moving toward equitable health care</i>	<i>La Costa (Marriott)</i>
<i>3–4 p.m.</i>	<i>Recruiting, retaining, retraining, and rewarding community physicians</i>	Grand Hall D
<i>3:30–4:15 p.m.</i>	<i>Unraveling the mysteries of surprise billing</i>	<i>Coronado (Marriott)</i>
<i>4–5 p.m.</i>	<i>Healthcare think tank: Members Moving Medicine</i>	<i>La Costa (Marriott)</i>
<i>5 p.m.</i>	OSMAP reception	Harbor Ballroom D-F

Locations are subject to change. All locations are in the Manchester Grand Hyatt unless otherwise specified and indicated by italics.
 * † *AMA PRA Category 1 Credit™* available for this session.

Time	Event	Location†
Saturday, November 16		
6:45–9:30 a.m.	Surgical Caucus business meeting and Handbook review	Coronado E
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
8–8:45 a.m.	<i>US health care reform—Diving into economic, physician, and patient aspects of proposed health care</i>	<i>La Costa (Marriott)</i>
8–10 a.m.	<i>Hearing tests</i>	<i>Mission Hills (Marriott)</i>
8:30–9:15 a.m.	<i>Developing sustainable global health projects in the age of voluntourism</i>	<i>Coronado (Marriott)</i>
9–9:45 a.m.	Amplify your voice: How physicians can shape health policy	Harbor Ballroom G-H
9–9:45 a.m.	<i>Identifying clinical problems and driving needs-oriented innovation in medicine</i>	<i>La Costa (Marriott)</i>
9 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
9:30–10:15 a.m.	<i>Using cost-effectiveness to determine coverage priorities</i>	<i>Coronado (Marriott)</i>
9:45–11 a.m.	The new MOC: Continuing board certification	Grand Hall D
10–10:45 a.m.	<i>Telemedicine and mobile apps—Accessing birth control without stepping foot in a clinic</i>	<i>La Costa (Marriott)</i>
Noon–1:30 p.m.	The impact of vision and hearing loss in the senior population—Why seeing and hearing are believing	Grand Hall C
2–6 p.m.	House of Delegates Opening Session	Seaport Ballroom
5:15–6 p.m.	Fair market pricing for prescription drugs	Harbor Ballroom B
6–6:30 p.m.	Investigating gender bias in medical student evaluations	Harbor Ballroom A
6:30 p.m.	Catholic Mass	Grand Hall C
Sunday, November 17		
7 a.m.–4 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
7:30 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
8–8:30 a.m.	AMA House of Delegates Business Session	Seaport Ballroom
8:30 a.m.–noon	Reference Committee on Amendments to Constitution and Bylaws	Grand Hall C
8:30 a.m.–noon	Reference Committee B	Harbor Ballroom G-I
8:30 a.m.–noon	Reference Committee C	Harbor Ballroom A-C
8:30 a.m.–noon	Reference Committee F	Seaport Ballroom
8:30 a.m.–noon	Reference Committee J	Harbor Ballroom D-F
8:30 a.m.–noon	Reference Committee K	Grand Hall D
Noon	Deadline for election announcements to be shown at I-19	Speakers' Office
1 p.m.	Rural Health Caucus	Regatta
1 p.m.	Election Task Force open forum	Grand Hall D
1–3:30 p.m.	Health Impact of Climate Change - Preparing Your Communities and Practices	Harbor Ballroom A-B
2–2:45 p.m.	AMA Ambassador Training – Onboarding	America's Cup A-B
2–3:30 p.m.	*Training Physicians in the Art of the Public Forum	City View
2–4 p.m.	Litigation Center Open Meeting	Harbor Ballroom D-F
2:30–3:30 p.m.	Back to basics: The fundamentals of extraordinary leadership	Coronado D
3–4 p.m.	AMA Ambassador Training – Personal and professional brand	America's Cup A-B
3–4 p.m.	AMA Ambassador Training – Social media	America's Cup C-D
3–4 p.m.	AMPAC Presents an Insiders "How to" Guide to Running and Winning a Campaign	La Jolla Grand Hall C
3–4:30 p.m.	Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021	Harbor Ballroom G-I
4–5 p.m.	AMA Ambassador Training – Why are you an AMA member	America's Cup A-B
4–5 p.m.	AMA Ambassador Training – Smarp	America's Cup C-D
5–6 p.m.	Obesity Caucus	Balboa
6:30–10:30 p.m.	<i>CMA Welcome to California Mixer</i>	<i>USS Midway (complimentary shuttle available)</i>

Locations are subject to change. All locations are in the Manchester Grand Hyatt unless otherwise specified and indicated by italics.

* † *AMA PRA Category 1 Credit™* available for this session.

Time	Event	Location†
Monday, November 18		
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
8–9:30 a.m.	*Training Physicians in the Art of the Public Forum	La Jolla Grand Hall D
9–10 a.m.	COL Forum	Harbor Ballroom D-F
9 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
9:30–11:30 a.m.	*CEJA Open Forum	Grand Hall C
9:30–11:30 a.m.	President's panel: Physicians' obligation to lead	Harbor Ballroom C
10–11 a.m.	†Is there a doctor on board? – Dealing with in-flight emergencies	Grand Hall D
11:30 a.m.	Private Practice Physician Congress	Harbor Ballroom A-B
Noon–1:30 p.m.	AMPAC Capitol Club Luncheon	TBD
2–6 p.m.	House of Delegates Business Session	Seaport Ballroom
Tuesday, November 19		
7 a.m.–noon	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–noon	Childcare availability	Manchester Grand Hyatt
8–11:30 a.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
8:30 a.m.–noon	House of Delegates Business Session	Seaport Ballroom

This form is for Delegate and Alternate Delegate Registrants

**You must complete this form and return it to staff at the AMA registration desk in San Diego to receive your credentials for the 2019 Interim Meeting of the House of Delegates.
See Policy G-600.032**

Name (please print): _____

HOD CONTACT INFORMATION

Please provide the contact information that should be used for House of Delegates business. This information will also appear in the pictorial directory unless you indicate otherwise (please print):

Mailing address: _____

City, State Zip code: _____

Phone 1: _____ Phone 2: _____

Email: _____

This is an update / correction. Please do not include in pictorial directory.

EMERGENCY CONTACT INFORMATION FOR I-19

Cell phone while at meeting: _____

Emergency contact name: _____

Emergency contact phone: _____

TITLE OF THIS SECTION

I acknowledge that I have been made aware of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," and have had the opportunity to review the policy. I hereby agree to conduct myself in accord with the policy.

_____ Signature

Return this completed form at the HOD registration desk in San Diego.