AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

November 2020 Medical Student Section (MSS) Meeting
Virtual
November 6-8

Policy Materials

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 001
(November 2020)

Introduced by: Tara Shelby, Akash Dhawan and Nikhi Linaval, Keck School of Medicine of USC; Valerie Du, Baylor School of Medicine; Melanie Schroeder, University of Arizona School of Medicine

Sponsored by: Region 1, Region 3

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Personal days are defined as excused absences that require advance notice from the student to the school without necessary explanation for the absence and are separate from sick days in that sick days may require proof of illness, as opposed to maintenance of self-care, physical and mental wellness[1]; and

Whereas, Burnout is a syndrome characterized by emotional exhaustion and depersonalization as a result of prolonged stress that can undermine professional development, and contribute to a variety of serious mental health disorders including suicidal ideation and substance use disorder[2]; and

Whereas, Burnout is present in at least half of all medical students across the U.S. at some point in their medical education[2]; and

Whereas, Note that all Whereas clauses should start with a capitalized word and end with "; and"[2-4]; and

Whereas, Among medical students, the prevalence of depression/depressive symptoms has been reported to be 27.2% and suicidal ideation was 11.1% as compared to 7.1% and 4% in the general population, respectively[3,4]; and

Whereas, Medical students self-reported that two of the top five stressors were lack of work-life balance and social interactions with family and friends[5]; and

Whereas, The lack of time is considered the number one barrier preventing medical students from getting mental health treatment[6]; and

Whereas, Students are unwilling to confess that they may be dealing with a mental illness due to stigma in the health professions, feelings of shame in front of their peers, and fear of potential effects on their professional development[7]; and

Whereas, Student psychological distress is associated with negative characteristics such as cynicism, an unwillingness to care for the chronically ill, and decreased empathy[2]; and

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Whereas, only 12% of workplaces in the U.S. offered this benefit in 2012, 36% of workplaces in the US now explicitly offer their employees personal days, apart from vacation and sick leave[11]; and

Whereas, There are active personal day policies implemented by various corporations including Netflix, Best Buy, Virgin America, and the tech company FullContact designed to promote the physical and mental well being of their employees[9]; and

Whereas, These policies include requiring a minimum of mandatory personal days, offering unlimited personal days, and providing stipends to incentivize time off, which potentially could provide a framework for implementation in healthcare[9]; and

Whereas, In a study of working Americans, taking personal time to focus on non-work related considerations, such as self-care and social interaction, has been shown to improve mood (68 percent), increase energy (66 percent) and increase motivation (57 percent), decrease stress (57 percent), increase productivity (58 percent) and increase their quality of work (55 percent)[10]; and

Whereas, Some medical schools are attempting to promote self-care by providing personal days during the clerkship year[12-21]; and

Whereas, The number and ability to take personal days isn't standardized across U.S. medical schools, as evidenced by the lack of mention or definition for personal days in many policies upon review of twenty-one institutions[8,13-20, 21-33]; and

Whereas, While there is AMA policy discussing burnout and mental health leave (D-310.968) and a resolution in consideration surrounding mental health as a valid use of a sick day (Resolution 37 Interim MSS Meeting 2019), there is no discussion or mention of personal days; and

Whereas, Our AMA has policy supporting existing programs in identification and management of stress (H-405.957), prioritizing self-care among medical students and the maintenance of a healthy lifestyle (H-405.957), and promoting the recognition of burnout in students by institutional officials, program directors, resident physicians, and attending faculty (H-295.858); therefore be it

RESOLVED, That our AMA recognizes the importance of personal days as health resources to ensure appropriate self-care and maintenance of a healthy lifestyle through amending Policy H-295.858, “Access to Confidential Health Services” by addition as follows:

> **Access to Confidential Health Services, H-295.858:**
> 1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
> A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on

patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

<u>E. Support a clearly defined number of personal days for medical students per academic year, a subset of which should be granted without explanation. Personal day policies should be easily accessible and explained to students at the beginning of each academic year.</u>

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students on an opt-out basis;

B. ensure anonymity, confidentiality, and protection from administrative action;

C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and

D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based

solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Fiscal Note: TBD

Date Received: 09/20/2020

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Click here to enter references. References should follow the AMA Reference Citation Format. Sample citations are shown below.

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RELEVANT AMA AND AMA-MSS POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

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A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of

students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16Appended: Res. 301, A-17Appended: Res. 303, A-17Modified: CME Rep. 01, A-18Appended: Res. 312, A-18Reaffirmed: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Res. 15, A-15Appended: Res. 608, A-16Reaffirmed: BOT Rep. 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
CME Rep. 06, A-19

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

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3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
CME Rep. 8, A-07Modified: Res. 919, I-11Modified: BOT Rep. 15, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 002
(November 2020)

Introduced by: Anmol Gupta, Baylor College of Medicine; Megan Jiao, McGovern School of Medicine at UTHealth at Houston

Sponsored by: Region 3

Subject: Encourage Transparency of Federal Funding Contracts for COVID-19 diagnostics, therapeutics, and vaccines

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Since the start of the current pandemic, the U.S. government has played a vital role in developing new solutions for COVID-19, allocating over 10 billion dollars in tax-payer funds for the research, development, and production (R&D) of diagnostics, therapeutics, and vaccines for the disease[1]; and

Whereas, In many cases, these public funds represent the majority of the financial capital used in the R&D of these endeavors[2,3]; and

Whereas, However, to date, there is no evidence of clear and binding commitments on behalf of the federal government that would ensure affordability and accessibility of any diagnostic, therapeutic, or vaccine developed with significant public investment, leaving the U.S. public to assume a majority of the financial risk and private companies, who receive these funds, the opportunity to reap all financial reward of a successful discovery[2,3,4]; and

Whereas, For example, taxpayer money has funded 100% of Moderna's leading vaccine candidate that is currently in a Phase III clinical trial, yet the company intends to introduce the vaccine at a price as high as 37 USD per dose if approved[5,6]; and

Whereas, Moderna has been accused of failing to disclose U.S. government funding in its patent applications, resulting in an investigation by The Department of Defense's Defense Advanced Research Projects Agency (DARPA) to identify and require reporting of all patents and pending patents associated with public monetary support[6]; and

Whereas, The National Institutes of Health (NIH) has claimed joint ownership of the vaccine candidate's intellectual property given that public funds completely fund the R&D of this technology, potentially allowing it to exercise existing rights that ensure its affordability and necessary supply[5,7,8,9]; and

Whereas, Another example is the drug Remdesivir, an important therapy for critically-ill COVID-19 patients[10,11]; taxpayers have contributed at least 78 million USD to develop the drug, yet Gilead, which now manufactures the drug, has been unable to ensure a supply sufficient to alleviate health needs while raising the price for patients and governments[10,11]; and

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Whereas, In response, over 30 state attorney generals have written a public letter to the HHS secretary asking the federal government to recognize the significant role public funds played in the development of Remdesivir and for the NIH and Food and Drug Administration (FDA) to exercise their march-in rights under the Bayh-Dole Act to allow for generic manufacturing[10]; and

Whereas, As this pandemic progresses, new federal contracts for research, development, and production have been allocated with unprecedented frequency; and

Whereas, Yet, there continues to be limited public transparency of these contracts, resulting in the introduction of bipartisan legislation that proposes to track allocation of public funds for COVID-19 R&D to-date[11,12,13,14]; and

Whereas, The American Medical Association has already prioritized the need for increased transparency regarding COVID-19 vaccines, advocating for “transparency regarding the process for authorization or licensure, standards for review, and safety and efficacy” in a written letter sent to the U.S. FDA Commissioner[15]; and

Whereas, Contract details released under the Freedom of Information Act have revealed existence of “Other Transactions Authority” terms that weaken or eliminate Bayh-Dole safeguards that currently allow the federal government to ensure affordability of medicines, especially those developed with public funds, in the midst of a public health crisis[4,16]; and

Whereas, 35 U.S.C § 201 dictates the practical application of patents developed with federal assistance be made “available to the public on reasonable terms[17]; and

Whereas, The Bayh-Dole Act allows the federal government to provide third-party licenses for the purpose of generating market competition when a technology is not made available under “reasonable terms”[18,19]; and

Whereas, Without transparency of these contracts, it may difficult to hold private manufacturers accountable regarding their distribution and pricing of essential COVID-19 solutions[4,7,8,9,20]; and

Whereas, In March, Secretary of Health and Human Services Alex Azar stated that he was unable to assure that a COVID-19 vaccine would be affordable, even if it was developed with taxpayer funds[21]; therefore be it.

RESOLVED, That our AMA advocates for full transparency of all past, current, and future government contracts that provide tax-payer funds for COVID-19 related diagnostics, therapeutics, and vaccines; and be it further

RESOLVED, That our AMA opposes government contracts from limiting or eliminating existing Bayh-Dole safeguards; and be it further

RESOLVED, That our AMA advocates for the U.S. federal government to use march-in-rights as provided by the Bayh-Dole Act for the purpose of ensuring accessibility and affordability for COVID-19 diagnostics, therapeutics, and vaccines that are developed with significant monetary investment by the public.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Price Transparence D-155.987: Price Transparency

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g.,

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

Price of Medicine H-110.991: Price of Medicine
1. 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 o
rder 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.

Pharmaceutical Costs H-110.987: Pharmaceutical Costs
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.

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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.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 003
(November 2020)

Introduced by: David Long, Tulane University School of Medicine; Pooja Patel, University of Iowa; Harrison Khong, Des Moines University; Amna Haider, Haeinn Woo, New York Institute of Technology COM; Jerome Soldo, University of Louisville SOM; Drayton Harvey, Keck School of Medicine of USC; Titus Hou, University of Illinois COM - Rockford; Natasha McGlaun, University of Nevada, Reno School of Medicine; Dayna Isaacs, University of California, Davis School of Medicine; Aaishwariya Gulani, University of Central Florida College of Medicine, Daniel Park Touro University California; Rohan Khazanchi, University of Nebraska Medical Center; Neha Siddiqui, Carle College of Medicine; Alysa Edwards, University of Colorado Anschutz; Ellena Popova, Perelman School of Medicine; Zoe Moyer, Virginia Commonwealth University; Tristan Mackey, School of Medicine Greenville-University of South Carolina

Sponsored by: Region 1,Region 2, Region 4, Region 5, Region 6

Subject: Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The United States government manages the largest immigration detention system in the world[1]; and

Whereas, The U.S. Customs and Border Patrol (CBP) and U.S. Immigration and Customs Enforcement (ICE), both under the jurisdiction of the Department of Homeland Security (DHS), are meant primarily to process non-US citizens (immigrants, migrants, and asylum seekers) and the intention of their detention centers is to temporarily hold people until their cases are heard or they are deported[2,3]; and

Whereas, For ICE detention facilities, a 2019 report by DHS Office of the Inspector General found 14,000 health and safety deficiencies mainly related to physical and mental health care procedures for detainees[4]; and

Whereas, 23 deaths (42% of deaths) occurred due to substandard care in ICE immigrant detention centers between 2010 and 2018[5]; and

Whereas, For CBP detention facilities, a 2019 report by DHS Office of Inspector General showed that prolonged detention in overcrowded CBP facilities has resulted in unhealthy living conditions, including sparse bathing and cleaning supplies, which has been confirmed by attorneys of the detainees[6,7]; and

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Whereas, Increased duration of detention is associated with increased symptom severity with respect to mental health conditions including post-traumatic stress disorder and depression[8]; and

Whereas, No empirical evidence supports the assumption that the threat of being detained deters irregular migration[9]; and

Whereas, Policy organizations across the political spectrum agree that there are viable alternatives to immigrant detention centers overseen by the Department of Homeland Security (DHS)[10-12]; and

Whereas, Alternatives to Detention (ATD) programs include the Intensive Supervision Appearance Program, Bonds, Family Case Management Program, and Community Management Programs, which include one or more of caseworker assignments, home check-ins, ICE check-ins, and/or telephonic monitoring[10,11,13,14]; and

Whereas, International program data on ATDs demonstrate improved health outcomes, decreased costs, increased compliance with immigration check-ins and hearings, and preserved family unity compared to detainment[9,14,15]; and

Whereas, The United States Government Accountability Office reported that the daily cost of ATDs is less than 7% of that of detention centers, thus ATDs cost less than seven cents for every dollar required to operate detention centers[15]; and

Whereas, The FCMP also demonstrated that ATD programs could be more economic than detention centers, costing approximately $38.47 per family per day as compared to $237.60 per family per day[16]; and

Whereas, 99% of the 630 asylum seekers who participated in the Family Case Management Program (FCMP), an ICE-run ATD program, complied with ICE monitoring requirements[16]; and

Whereas, Previously implemented ATD programs such as the Community Support Initiative and the Appearance Assistance Program showed similarly high rates of compliance to FMCP[12,17]; and

Whereas, The American Academy of Pediatrics, the American College of Physicians, and Doctors for Camp Closure have recommended the use of ATD programs for immigrants, and particularly for children[18,19]; and

Whereas, ATD programs would achieve the healthcare quality goals of AMA policy D-350.983 for improving medical care in immigrant detention centers, and better align with our policy H-65.965 on human dignity and human rights; and

Whereas, The term ATD is broadly defined and inclusive of alternatives that could be considered exploitative or inhumane, such as applying high bail bonds or excessive surveillance, thus creating a need to distinguish between ATD programs that respect human dignity and those that do not[10]; and

Whereas, Our AMA supports “the dignity of the individual, human rights and the sanctity of human life,” (H-65.965); therefore be it

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RESOLVED, That our AMA advocates for the preferential use of Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at Interim 2020.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Res. 017, A-17

Care of Women and Children in Family Immigration Detention H-350.955
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.

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4. Our AMA will advocate for access to health care for women and children in immigration detention.
Res. 002, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14 Reaffirmed in lieu of: Res. 001, I-16 Reaffirmation: A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(November 2020)

Introduced by: Danielle Rivera, Cody Moezzi, Sally Midani, University of New Mexico School of Medicine; Melanie Schroeder, University of Arizona College of Medicine - Phoenix

Sponsored by: Region 1, Region 2, Region 6

Subject: Amending D-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, At the start of the COVID-19 pandemic in March 2020, U.S. hospitals faced critical shortages of essential medical supplies such as personal protective equipment (PPE), testing materials, and ventilators necessary for healthcare management and medical staff safety[1]; and

Whereas, A study found that healthcare workers who were either reusing PPE or had inadequate PPE saw increased hazard ratios of contracting COVID-19 of 1.46 and 1.31 respectively[2]; and

Whereas, On March 19, 2020, President Trump signed the Defense Production Act (DPA) under the pretense of invoking its authority only as a “worst case scenario in the future”[3]; and

Whereas, On March 31, 2020, the AMA called upon President Trump to utilize the DPA to address the severe shortage of PPE in the U.S.[4]; and

Whereas, The Strategic National Stockpile (SNS) was designed to supplement state and local reserves of medical supplies during public health and natural disaster emergencies[5,6,7]; and

Whereas, Former SNS administrators stated that “hospitals and states would create their own stockpiles, and under extenuating circumstances—when they ran out of supplies, or if they were incapacitated for some reason—they could fall back on the national stockpile”[6]; and

Whereas, Even at full capacity, the SNS is incapable meeting the nation’s PPE needs in a pandemic, was only capable of addressing a few states’ needs at a time, and was seldom at full capacity due to insufficient Congressional appropriations[8,9]; and

Whereas, At the beginning of the COVID-19 outbreak the SNS contained 12 million of the 3.5 billion N95 masks federal officials estimated were necessary for the pandemic[6,8]; and

Whereas, On April 1, 2020, only a few weeks after the World Health Organization declared a pandemic, the SNS was nearly out of all PPE supplies because it was not restocked after the swine flu pandemic in 2009 and left over supplies had expired[5-11]; and

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Whereas, Nationwide shortages in testing materials hindered/set back access to COVID-19 testing, and led to week-long delays for results, both of which resulted in insufficient testing to reduce infection spread[12,13]; and

Whereas, On April 1, 2020, 1.5 million expired N95 masks were distributed to the Transportation Security Administration and Customs Enforcement personnel, however, there are no programs to assess and extend the shelf-life of PPE[7,11];and

Whereas, SNS supplies were distributed both inefficiently and to the wrong locations due to allocations based upon outdated projections[14]; and

Whereas, Alternatives to current PPE distribution methods like computing-based healthcare databases allow for PPE distribution in real time, lowering the cost and increasing distribution effectiveness[15,16]; and

Whereas, The AMA has twice called for the White House Coronavirus Task Force to incentivize the manufacturing and distribution of PPE[17,18]; and

Whereas, On June 26, 2020, in a letter to the Senate Committee on Health, Education, Labor, and Pensions, the AMA highlighted the importance of "creating better coordination across federal and state governments and streamlining pandemic response logistics" and "enhancing state and federal stockpiles and improving the system for acquisition and distribution of medically necessary supplies[19];" therefore be it

RESOLVED, That our AMA amend policy D-440.847 by addition and deletion as follows:

Pandemic Preparedness ~~for Influenza~~ D-440.847

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a~~n influenza~~ pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local

health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;

(3) encourages states and tribal communities to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(~~3~~4) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~5) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(6) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States.

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY.

Pandemic Preparedness for Influenza D-440.847
In order to prepare for a potential influenza pandemic, our AMA:

1. urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency;

2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency;

3. urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

4. supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

6. will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

AMA Role in Addressing Epidemics and Pandemics H-440.835

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1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.

2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.

3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.

4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.

5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.

6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

Code of Medical Ethics Opinion 8.4: Ethical Use of Quarantine & Isolation

Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.

With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:

(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.

(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.

(c) Encourage patients to adhere voluntarily to quarantine and isolation.

(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.

(e) Inform patients about and comply with mandatory public health reporting requirements.

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(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.

(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.

The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:

(h) Ensure that quarantine measures are ethically and scientifically sound:

1. Use the least restrictive means available to control disease in the community while protecting individual rights
2. Without bias against any class or category of patients

(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.

(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.

(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.

(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

Code of Medical Ethics Opinion 2.25: The Use of Quarantine and Isolations as Public Health Interventions

Quarantine and isolation to protect the population's health potentially conflict with the individual rights of liberty and self-determination. The medical profession, in collaboration with public health colleagues, must take an active role in ensuring that those interventions are based on science and are applied according to certain ethical considerations.

1. To this end, the medical profession should:
   a) seek an appropriate balance of public needs and individual restraints so that quarantine and isolation use the least restrictive measures available that will minimize negative effects on the community through disease control while providing protections for individual rights;
   b) help ensure that quarantine and isolation are based upon valid science and do not arbitrarily target socioeconomic, racial, or ethnic groups;
   c) advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting;
   d) advocate for access to public health services to ensure timely detection of risks and prevent undue delays in the implementation of quarantine and isolation;
   e) help to educate patients and the public about quarantine and isolation through the development of educational materials and participation in educational programs;

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f) advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases.

2. Individual physicians should participate in the implementation of appropriate quarantine and isolation measures as part of their obligation to provide medical care during epidemics (see Opinion E-9.067, “Physician Obligation in Disaster Preparedness and Response”). In doing so, advocacy for their individual patients’ best interests remains paramount (see Opinion E-10.015, “The Patient-Physician Relationship”). Accordingly, physicians should:
   a) encourage patients to adhere voluntarily to scientifically grounded quarantine and isolation measures by educating them about the nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient;
   b) comply with mandatory reporting requirements and inform patients of such reports;
   c) minimize the risk of transmitting infectious diseases from physician to patient and ensure that they remain available to provide necessary medical services by using appropriate protective and preventive measures, seeking medical evaluation and treatment if they suspect themselves to be infected, and adhering to mandated public health measures.
3. Frontline physicians have an increased ethical obligation to avail themselves of safe and effective protective and preventive measures (for example, influenza vaccine).

Code of Medical Ethics Opinion 9.067: Physician Obligation in Disaster Preparedness and Response

National, regional, and local responses to epidemics, terrorist attacks, and other disasters require extensive involvement of physicians. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health or life. The physician workforce, however, is not an unlimited resource; therefore, when participating in disaster responses, physicians should balance immediate benefits to individual patients with ability to care for patients in the future.

In preparing for epidemics, terrorist attacks, and other disasters, physicians as a profession must provide medical expertise and work with others to develop public health policies that are designed to improve the effectiveness and availability of medical care during such events. These policies must be based on sound science and respect for patients. Physicians also must advocate for and, when appropriate, participate in the conduct of ethically sound biomedical research to inform these policy decisions. Moreover, individual physicians should take appropriate advance measures to ensure their ability to provide medical services at the time of disasters, including the acquisition and maintenance of relevant knowledge.

440.034MSS Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning and Response

AMA-MSS will ask the AMA to support skill-appropriate medical student involvement in pandemic disaster medicine and public health preparedness planning and response.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 005
(November 2020)

Introduced by: Rowena Hann, Jessica Mitter, Touro University California College of Osteopathic Medicine; Abby Rentschler, Michigan State University College of Human Medicine; Lauren Lin, University of Pittsburgh School of Medicine; Victoria Gordon, Kansas City University of Medicine and Biosciences; Nikita Sood, Washington University School of Medicine in St Louis; Christopher Wong, Baylor College of Medicine

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, Region 7

Subject: Support Public Health Approaches for the Prevention and Management of COVID-19 in Correctional Facilities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, COVID-19 is an infectious disease caused by SARS-CoV-2 that spreads rapidly between individuals in close contact, presents more severely in people above age 60 with chronic health conditions, and disproportionately impacts racial and ethnic minorities[1,2,3,4]; and

Whereas, Many opportunities exist for COVID-19 to be introduced into correctional facilities, in which individuals facing incarceration live in crowded environments, are not permitted to leave, and are exposed to others who have transferred between facilities[5,6]; and

Whereas, In 2013, over 130,000 people experiencing incarceration were older than 55, and in 2011-2012, over 40% of those incarcerated in state and federal institutions reported having chronic health problems[5,7,8,9]; and

Whereas, The incarceration rate of Native American and Black individuals is two times and five times that of white individuals, respectively, and approximately three out of five individuals in prison are Black or Latinx — nearly double their proportion of the country's population[10,11]; and

Whereas, Adjusted for age, Black, Latinx, and Native American individuals are more than three times more likely to die of COVID-19 than their white counterparts, and Black Americans make up the largest racial group in 10 out of 20 US counties with the highest COVID-19 deaths per capita[12,13]; and

Whereas, Identification, isolation, and treatment of cases in incarcerated individuals is often delayed due to inadequate healthcare funding and high patient medical copays[6]; and

Whereas, More than 120,000 people that are incarcerated in state and federal prisons have tested positive for COVID-19 and over 1,000 have died from the disease, with new cases per week continuing to increase since late June[14]; and

Whereas, Of the top 20 largest disease clusters in the country, 19 are in prisons or jails, with a growth rate that doubly outpaces the general population[15]; and

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Whereas, The COVID-19 outbreak at San Quentin prison is expected to spread past the prison walls and overwhelm the local health care system, suggesting that these outbreaks threaten public health efforts in the general population as well[15]; and

Whereas, Testing rates differ substantially between prisons, with some conducting mass testing and others testing only symptomatic individuals who are incarcerated, suggesting that current estimates of COVID-19 prevalence in prisons may fall short of actual numbers[16]; and

Whereas, Most states have released incomplete or no demographic information on COVID-19 cases and deaths within the incarcerated population, limiting the understanding and development of efforts to address racial disparities[8,17,18]; and

Whereas, Public health experts have advocated for the release, or “decarceration”, of elderly and medically vulnerable individuals, as well as those least likely to commit additional crimes, to prevent the spread of COVID-19[19,20,21]; and

Whereas, Since March 2020, states across the country have begun releasing non-violent, medically vulnerable individuals experiencing incarceration, resulting in an 11% reduction in the California state prison census and a 25% reduction in the North Dakota state prison population[22]; and

Whereas, Illinois, California, Colorado, and Oklahoma have aimed to reduce prison admissions by halting new admissions or arrests for low level parole violations in order to reduce the risk of viral transmission into the prison population[23]; and

Whereas, A 17% reduction in California’s prison population to reduce overcrowding from 2011 to 2012 had no effect on crime rates after three years, suggesting that decarceration of nonviolent offenders poses minimal threat to public safety[24]; and

Whereas, Of 29 county jail systems studied, 28 had all reduced their jail population between the months of February and April 2020, yet less crime occurred over the subsequent months as compared to monthly trends over the past two years[25]; and

Whereas, Strategies to minimize COVID-19 spread among staff and those that remain incarcerated include universally available COVID-19 screening, testing, and care, access to sanitation, space to maintain social distancing, and appropriate personal protective equipment[21]; and

Whereas, In Ireland, prison-led contact tracing programs detected 45 COVID-19 cases in staff members but no cases in tested people who are incarcerated and were under investigation for possible exposure, supporting the use of contact tracing to mitigate the spread of disease in such closed institutions[26]; and

Whereas, The National Commission on Correctional Health Care and the CDC have released specific guidance for controlling the spread of COVID-19 in correctional and detention facilities, including hand washing, employee PPE training, and establishment of disease outbreak protocols in the event of an outbreak to ensure adequate preparation and open lines of communication with local health officials[27]; and

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Whereas, Despite a Prison Policy Initiative Report that found that all but 3 states had reported providing masks to all staff, there have also been several accounts of non-adherence to PPE requirements by staff as well as "a lack of transparency around policies for… PPE and testing" for staff in correctional and detention facilities[28,29,30]; and

Whereas, Further accounts have alleged that incarcerated individuals are being punished for wearing face coverings and are banned from using sanitation materials like hand sanitizer[28,29]; and

Whereas, Our AMA prescribes specific plans and supports collaboration between medical, public health, and criminal justice systems to prevent and control the spread of HIV/AIDS, tuberculosis, and hepatitis C but does not identify other infectious respiratory diseases in its policies (H-430.985, H-430.988, H-430.989, H-440.931); and

Whereas, Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism (H-430.997); and therefore be it

RESOLVED, That our AMA collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious respiratory pathogens in the setting of prisons and jails, including, but not limited to:

(a) Universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated
(b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies
(c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens
(d) Adherence to use of personal protective equipment for incarcerated individuals and staff
(e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; and be it further

RESOLVED, That our AMA will support efforts to decarcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious respiratory pathogens within correctional facilities and communities; and be it further

RESOLVED, That our AMA will amend policy H-430.989 by insertion as follows:

> **Disease Prevention and Health Promotion in Correctional Institutions H-430.989**
>
> Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, ~~and~~ hepatitis, and highly contagious infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in

direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.; and be it further

RESOLVED, That this resolution be forwarded immediately to the House of Delegates at I-20.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.
Res. 404, A-17

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers

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and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Testing for HIV infection and tuberculosis should be mandatory for all prisoners within 60 days of their release from prison; e) Physicians who practice in correctional institutions should evaluate all tuberculin-positive inmates for HIV infection and all HIV-positive patients for tuberculosis, since HIV status may affect subsequent management of tuberculosis infection or disease and tuberculosis may accompany HIV infection; f) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; g) During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or needle-sharing partners; and h) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies.
(2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities.
(3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment

centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Update on Tuberculosis H-440.931
It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.
BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by

the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

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

Co-payments in Prisons 65.033MSS
AMA-MSS will ask the AMA to advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities (MSS Res. 04, I-19)

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 006
(November 2020)

Introduced by: Shyon Parsa, University of Texas Southwestern Medical School; Meghana Chanamolu, Northeast Ohio Medical University; Joseph Camarano, University of Texas Medical Branch School of Medicine

Sponsored by: N/A

Subject: Supporting Medical Student Guidelines During Healthcare Crisis.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, the World Health Organization declared COVID-19 a worldwide pandemic on March 11th 2020[1]; and

Whereas, The Association of American Medical Colleges strongly suggested medical student suspensions of patient care activities for extended periods of time[2] leaving medical students with more time to commit as they see fit; and

Whereas, The fewer than 65,000 physicians and advanced nursing intensivists and 550,000 critical care nurses in the United States[3] would be insufficient to provide care to the estimated 2.9 million Americans that might need COVID-related ICU care[4]; and

Whereas, Medical students around the country from schools such as University of Michigan Medical School[5], Harvard Medical School[6], Yale Medical School[7], and UT Southwestern Medical School[8], have established a medical response teams involving low-risk roles such as managing the COVID hotline, entrance screenings, and contacting patients with outpatient procedures[5,6,7,8]; and

Whereas, Despite the efforts many medical schools and students are engaging in[5,6,7,8], there is still great need for personnel help that medical students would be in a position to fill[9]; and

Whereas, The lack of an official statement for weeks after the inception of the pandemic[10] as to the extent of medical student participation in the COVID crisis has led to a widely varied response from individual medical schools student efforts[11,12] with concerns regarding medical student safety[12] and liability concerns[13]; and it be further

RESOLVED, That our AMA-MSS collaborate with relevant AMA stakeholders in order to develop and continuously revise as necessary recommendations regarding the role medical students are able to safely fill in a healthcare setting during a crisis that results in a significant departure from normal medical education as determined by the MSS governing council.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

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AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.
Sub. Res. 925, I-14Reaffirmed: Res. 418, A-17

Pandemic Preparedness for Influenza H-440.847
In order to prepare **for** a potential **influenza pandemic**, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers **for** Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare **for** and respond to an **influenza pandemic** or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) **for** the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care **for** large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare **for**, respond to, and protect the population from illness and death in an **influenza pandemic** or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an **influenza** epidemic, **pandemic**, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a **pandemic**; and (b) such agencies should publicize now, in advance of any such **pandemic**, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future **influenza** vaccine production or distribution problems and in developing a plan to respond to an **influenza pandemic** in the United States.
CSAPH Rep. 5, I-12Reaffirmation A-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 007
(November 2020)

Introduced by: Onu Udoh, Aarika Ferko, and Yomna Amer, University of Louisville Medical School; Sabrina Hennecke, University of Miami Miller School of Medicine; Arvinth Sethuraman, Rutgers-New Jersey Medical School; Vivian V. Altiery De Jesús, University of Puerto Rico School of Medicine; Syeda Akila Ally, University of Illinois College of Medicine; Lawson Traylor, University of South Carolina School of Medicine Greenville; ChiuYing Cynthia Kuk, Michigan State University College of Human Medicine; Annie Yao, University of Connecticut School of Medicine

Sponsored by: Region 2, Region 5, Region 6, Region 7, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Subject: Representation of Dermatological Pathologies in Varying Skin Tones.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Worse healthcare outcomes result from the under recognition of dermatologic pathologies, such as erythema migrans and the late detection of melanoma in individuals with darker skin tones – also known as Fitzpatrick skin types III-VI[1-4]; and

Whereas, There is a higher probability that individuals with darker skin tones have late detection of disease when compared to lighter skin tones (Fitzpatrick skin types I-II)[5-8]; and

Whereas, There is a lack of targeted skin cancer awareness and prevention efforts for patients with darker skin tones[9] resulting in lower rates of skin cancer screening; and

Whereas, Research has demonstrated that patients with darker skin tones feel frustrated when dermatologists do not demonstrate competency recognizing and treating pathologies on darker skin[10]; and

Whereas, It has been shown that overrepresentation of minority group skin tones relative to their proportion in the population is required to achieve equitable diagnostic outcomes[11-13]; and

Whereas, About 75 percent of dermatological imagery in medical textbooks represent individuals with lighter skin tones while core dermatology textbooks used to educate trainees, dermatologists, and generalists have limited representations of skin of color[14]; and

Whereas, Terms such as “Classic Presentation” are usually examples of lighter skin tones[15]; and

Whereas, Although our AMA recognizes the importance of racial and ethnic disparities in healthcare (H-350.974), the terms “race” and “ethnicity” are not equivalent nor interchangeable with the genotypic and phenotypic characteristics of “skin tone”[16-18]; and

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Whereas, Our AMA-MSS supports the development of anti-racist competencies in undergraduate medical curriculum (295.194MSS), but our AMA does not address the importance of teaching the ranging pathological presentations in different skin tones at the undergraduate medical level; and

Whereas, Existing AMA policy "promote[s] education on the importance of skin cancer screening and skin cancer screening in patients of color" (H-55.972) but lacks policy to ensure medical students are adequately primed to recognize such pathologies in a variety of skin colors;

Whereas, While current AMA policy supports ensuring diversity in United States Medical Licensing Examination exam test/oversight committees representative of the test takers (D-275.963), this policy does not cover diversity in test questions themselves, nor the importance of skin tone as a relevant pathological factor missing in dermatological exam questions; and therefore be it

RESOLVED, That our AMA encourages medical schools to include a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluations; and be it further

RESOLVED, That our AMA works with relevant stakeholders to develop educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones, including support of the overrepresentation of darker skin tones in such materials.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Early Detection and Prevention of Skin Cancer H-55.972

Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and

public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. CCB/CLRPD Rep. 3, A-14

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. CME Rep. 11, A-06, Reaffirmation A-11, Modified in lieu of Res. 908, I-14, Reaffirmed in lieu of Res. 306, A-15, Reaffirmed: BOT Rep. 39, A-18, Modified: CME Rep. 01, A-20

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

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3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19

Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963
Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers. Sub. Res. 306, A-09, Reaffirmed: CME Rep. 01, A-19

Continued Support for Diversity in Medical Education D-295.963
1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups. Res. 325, A-03, Appended: CME Rep. 6, A-11, Modified: CME Rep. 3, A-13

Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum 295.194MSS
AMA-MSS (1) recognizes that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(November 2020)

Introduced by: Aida Haddad, Adrianne Khanolkar, Amani Karim, Sandra Jones, Indiana University School of Medicine; Raveen Sugantharaj, Danny Luong, Peter Boules, Marian University College of Osteopathic Medicine; Sally Midani, Danielle Rivera, Julio Avila, University of New Mexico School of Medicine; Samantha Pavlock, Florida State University College of Medicine; Melanie Schroeder, Spencer Bayless, Akshara Malla, University of Arizona College of Medicine - Phoenix; Kseniya Anishchenko, University of Colorado School of Medicine; Avi Levy, Midwestern University Arizona College of Osteopathic Medicine; Lauren Matsuno, University of California Los Angeles David Geffen School of Medicine; Alysa Edwards, University of Colorado Anschutz School of Medicine; Neha Siddiqui, Carle Illinois College of Medicine

Sponsored by: Region 1, Region 2, Region 4, Region 5

Subject: Protestor Protections

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Physicians nationwide agree that “protest is a profound public health intervention, because it allows [citizens] to finally address and end forms of inequality.”[1]; and

Whereas, The use of a variety of weapons and practices against peaceful protestors, including kinetic impact projectiles (KIPs), chemical irritants, and curfew enforcement has increased in the United States over the past year[2-9]; and

Whereas, KIPs, generally referred to as ‘rubber bullets,’ can include bean bag rounds (‘flexible batons’), sponge rounds, pellet rounds, and other projectiles made of hard plastic, rubber, mixtures of metal and foam, or shards of metal inside rubber bodies[2,10]; and

Whereas, KIPs are also known as 'less lethal weapons' because they are designed to incapacitate an individual without penetrating the body; but while 'less lethal,' their slower speed and irregular shapes result in unpredictable trajectories that can still result in severe injuries and death[2,10,11]; and

Whereas, A systematic review on deaths, injuries, and permanent disability from KIPs used in arrests, protests, and other contexts from 1990 to 2017 identified 2,135 injuries in 1,984 individuals injured, including 53 deaths and 300 individuals left with permanent disability[11]; and

Whereas, KIPs can lead to neurologic damage, pneumothorax, hemorrhage, and cardiac arrest, as recently demonstrated when a 26-year-old protester in Seattle, Washington was hit in the chest with a flash grenade precipitating in instantaneous cardiac arrest at the scene and twice again the next day[6-8,10,11]; and

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Whereas, The firing of KIPs for the purpose of crowd-control is not well validated and results are variable depending on the type of KIP, country of use, and manufacturer, rendering KIP use protocols inaccurate and harmful in crowd-control situations[9,11]; and

Whereas, Physicians for Human Rights (PHR) has identified "troubling levels of morbidity and even instances of death" caused by chemical irritants, and that KIPs "cause serious [preventable] injury, disability, and death from penetrative injuries and head, neck, and torso trauma"[10-12]; and

Whereas, According to PHR, the chemical irritants most commonly used by law enforcement as crowd-control agents are Agent CS gas (o-Chlorobenzylidene malononitrile), Agent OC gas (oleoresin capsicum), and PAVA gas (synthetic Agent OC)[12]; and

Whereas, A study on Agent CS gas showed that 27.9% of 1,148 Agent CS gas-induced injuries were categorized as 'severe,' where 'severe' injury "necessitated professional medical care"[13]; and

Whereas, Multiple studies reviewing the use of chemical irritants in crowd-control situations linked them to death and chronic disabilities, including but not limited to blindness, traumatic brain injury resulting in vegetative state, amputation, post-traumatic stress disorder, and persistent respiratory conditions[13, 14]; and

Whereas, Amnesty International guidelines state that "chemical irritants used in public order situations, including those delivered by hand thrown grenades or weapon launched projectiles by their very nature have an indiscriminate effect with a high probability of affecting not only those individuals who are engaged in violence, but also bystanders and peaceful demonstrators"[15]; and

Whereas, Chemical methods including the use of chemical sprays or projectiles embedded with chemicals to restrain an individual are considered "less-than-lethal" physical methods for de-escalation by the Journal of Police Crisis Negotiations[16]; and

Whereas, De-escalation has been shown to be nearly 60% effective in psychiatric settings, and the American Association for Emergency Psychiatry supports non-physical methods of de-escalation prior to pursuing physical methods[17, 18]; and

Whereas, During violent demonstrations in Sweden, law enforcement agencies deploy alternatives to crowd-control weapons in the form of specially-trained dialogue police officers focused on de-escalation and non-confrontation techniques to reduce violence[15,19]; and

Whereas, A study on KIP misuse in crowd-control found "an urgent need to establish international guidelines on the use of [crowd-control weapons] to prevent unnecessary injury, disability, and death, particularly in the use of operational models that avoid the use of weapons"[11]; and

Whereas, In a report identifying misuse of crowd-control weapons in the United States, Egypt, South Africa, Israel, Argentina, Hungary, England, and Canada, the International Network of Civil Liberties Organizations and PHR brought attention to the "significant gap in knowledge about the health effects" and "absence of meaningful international standards or guidelines around their use"[20]; and

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Whereas, the American Academy of Ophthalmology called for domestic law enforcement to immediately end the use of rubber bullets to disperse crowds due to risk of permanent vision loss[21]; and

Whereas, The AMA and the American Academy of Pediatrics released statements citing police brutality as a public health issue[22, 23]; and

Whereas, The AMA denounces the use of chemical weapons (H-520.992, H-515.964) and asserts that verbal and physical violence encounters between law enforcement officers and public citizens are social determinants of health; therefore be it

RESOLVED, That our AMA advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States; and be it further

RESOLVED, That our AMA discourage the use of crowd-control weapons that have not been thoroughly researched; and be it further

RESOLVED, That our AMA encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control weapons and techniques which minimize physical harm; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Chemical and Biologic Weapons H-520.992
Our AMA condemns the use of chemical and biologic weapons. Res. 175, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

Violence as a Public Health Issue H-515.979
The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Violence Activities H-515.964
Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes; (2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and (3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. BOT Rep. 9, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Public Health Policy Approach for Preventing Violence in America H-515.971
The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts. BOT Rep. 34, A-95; Reaffirmed by BOT Rep. 16, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmation A-13; Reaffirmation: A-18

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11

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Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in healthcare is an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority: (A) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (B) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (C) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in

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minority communities. BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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

Racism as a Public Health Threat 350.025MSS
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies. MSS Res. 30, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 009
(November 2020)

Introduced by: Danielle Rivera, University of New Mexico School of Medicine

Sponsored by: Region 1

Subject: Call for Increased Funding and Research for Post Viral Syndromes

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Post viral syndrome, also known as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), is frequently understood to be "overwhelming fatigue that is not improved by rest, and worsens after physical, mental, or emotional exertion"[1,2]; and

Whereas, The Institute of Medicine (IOM) developed diagnostic criteria for ME/CFS which require profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, orthostatic intolerance, and other symptoms[3]; and

Whereas, ME/CFS can be diagnosed through two consecutive days of cardiopulmonary exercise testing and may be supplemented by diagnostic tests like tilt-table testing and the NASA 10-minute lean test [4,5,6]; and

Whereas, ME/CFS can be significantly disabling, leading to challenges with school, work, and activities of daily living[1]; and

Whereas, ME/CFS can leave up to 25% of patients house- or bed-bound, sometimes for years[1]; and

Whereas, Current ME/CFS patients report stigmatization, marginalization, and have increased rates of suicide, in part due to the lack of understanding of their condition by physicians and the general public[3,7,8]; and

Whereas, Fewer than one-third of medical school curricula include information about ME/CFS, leading to a dearth of knowledge about how to diagnose and treat it[3]; and

Whereas, A Center for Disease Control study found that a significant portion of health care providers doubted or had misconceptions about the illness; for instance, a different study further found that 85% of providers thought the illness was wholly or partially psychiatric[3]; and

Whereas, 70% of physicians who had diagnosed a patient with ME/CFS felt the illness was more difficult to diagnose than other illnesses[3]; and

Whereas, An Institute of Medicine report estimates that between 836,000 and 2.5 million Americans suffer from ME/CFS, 90% of whom have not been diagnosed[7]; and

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Whereas, The same report found that ME/CFS costs the U.S. economy between $17 to $24 billion annually in medical bills and lost incomes[7]; and

Whereas, A study of Severe Acute Respiratory Syndrome (SARS) survivors unable to return to work due to lingering effects reported that their symptoms closely mirrored those seen in ME/CFS[3]; and

Whereas, A comprehensive study of SARS survivors found that 27.1% met the modified 1994 Centers for Disease Control and Prevention criteria for Chronic Fatigue Syndrome four years after infection[9]; and

Whereas, SARS is a coronavirus with a higher fatality rate than the Coronavirus Disease 2019 (COVID-19) but has similar clinical features[10]; and

Whereas, As of September 20, 2020, the spread of the COVID-19 has led to a global pandemic, with nearly 6.8 million infections and almost 200,000 deaths in the United States alone[11]; and

Whereas, A COVID-19 tracking system found that around 10% of symptomatic but not hospitalized COVID-19 patients had not fully recovered even months later and physicians have begun to report global incidences of post-viral syndromes presenting as chronic, fatigue-related symptoms similar to ME/CFS[7,12]; and

Whereas, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, stated that the post viral symptoms seen in COVID-19 patients are “highly suggestive” of ME/CFS and that it is “something we really need to seriously look at”[13]; therefore be it

RESOLVED, That our AMA will encourage Congress to enact legislation to provide funding for research, prevention, control, and treatment of post viral syndromes associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further

RESOLVED, That our AMA will support physicians in providing accurate and current information on post-viral syndromes, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further

RESOLVED, That our AMA will collaborate with other medical and educational entities to promote education of post-viral syndromes, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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Enhanced Zika Virus Public Health Action - Now D-440.930

1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.
2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.
3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

Funding of Biomedical, Translational, and Clinical Research H-460.926

Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research.

Viability of Clinical Research Coverages and Reimbursement H-460.965

Our AMA believes that:

(1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;

(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;

(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;

(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;

(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;

(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;

(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;

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(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;

(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.

Support of Biomedical Research H-460.998

Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal: (1) The support of biomedical research is the responsibility of both government and private resources.

(2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise.

(3) An appropriate balance must be struck between support of project grants and of contracts.

(4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously.

(5) Funds should be specifically appropriated to train personnel in biomedical research.

(6) Grants should be awarded under the peer review system.

(7) The roles of the private sector and of government in supporting biomedical research are complementary.

(8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research.

(9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research.

(10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 010
(November 2020)

Introduced by: Tsola Efejuku, University of Texas Medical Branch

Sponsored by: Region 3

Subject: Learning History of Experimentation on Black Bodies in Medicine To Understand Medical Mistrust

Referred to: MSS Reference Committee (Sarah Mae Smith, Chair)

Whereas, Black bodies have historically been used for experimentation through forced or misinformed consent[10,11,12]; and

Whereas, Significant medical advancements have been disproportionately achieved at the expense of black individuals subjected to improper experimentation, who often lack recognition for their participation in these unjust practices[,8,11,12]; and

Whereas, The development of the first consistently successful surgical technique for the repair of obstetric vesicovaginal fistulas by Dr. J Marion Sims was achieved through forced experimentation on enslaved black women[16], and

Whereas, The lack of education of the historic abuse of black people in the healthcare field has failed to mitigate implicit bias in graduate medical education[3]; and

Whereas, Physicians are not trained in competent cultural humility and continue to risk increased incidents of perpetuating inequitable care due to implicit bias[6,14,17]; and

Whereas, There is a statistical discrepancy in the quality of care towards black patients compared to their white counterparts, even when adjusted for socioeconomic factors[1,7,9]; and

Whereas, The statistical discrepancy in the quality of care towards black patients, even when controlling for relevant sociodemographic variables, is linked to disparities in patient-physician communication[15], and

Whereas, Historical medical discrepancies have led to a significant and justified distrust of healthcare professionals and decreased voluntary research trial participation[2,4,14,18], and

Whereas, Mistrust of healthcare professionals has contributed to poorer health outcomes and equity for black populations when compounded with other negative structural social determinants of health[13]; and

Whereas, Black women are three to four times more likely to experience a pregnancy-related death than white women, even when socioeconomic status is accounted for[19-20]; therefore be it

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RESOLVED, That our AMA promotes graduate medical education integration of historical context for medical advancements achieved through forced participation of black people that has contributed to current distrust in medicine.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through

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letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

7.2.2 Release of Data from Unethical Experiments
Research that violates the fundamental principle of respect for persons and basic standards of human dignity, such as Nazi experiments during World War II or from the US Public Health Service Tuskegee Syphilis Study, is unethical and of questionable scientific value. Data obtained from such cruel and inhumane experiments should virtually never be published. If data from unethical experiments can be replaced by data from ethically sound research and achieve the same ends, then such must be done. In the rare instances when ethically tainted data have been validated by rigorous scientific analysis, are the only data of such nature available, and human lives would certainly be lost without the knowledge obtained from the data, it may be permissible to use or publish findings from unethical experiments. Physicians who engage with data from unethical experiments as authors, peer reviewers, or editors of medical publications should: (a) Disclose that the data derive from studies that do not meet contemporary standards for the ethical conduct of research. (b) Clearly describe and acknowledge the unethical nature of the experiment(s) from which the data are derived. (c) Provide ethically compelling reasons for which the data are being released or cited, such as the need to save human lives when no other relevant data are available. (d) Pay respect to those who were the victims of the unethical experimentation.

10.8 Collaborative Care
In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

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An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.
As leaders within health care teams, physicians individually should:
(a) Model ethical leadership by:
(i) understanding the range of their own and other team members' skills and expertise and roles in the patient's care;
(ii) clearly articulating individual responsibilities and accountability;
(iii) encouraging insights from other members and being open to adopting them; and
(iv) mastering broad teamwork skills.
(b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.
(c) Help clarify expectations to support systematic, transparent decision making.
(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.
(e) Communicate appropriately with the patient and family and respect their unique relationship as members of the team.
As leaders within health care institutions, physicians individually and collectively should:
(f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
(g) Encourage their institutions to identify and constructively address barriers to effective collaboration.
(h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic

discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly

populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.

b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and

c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:

a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;

b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;

c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;

d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and

e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority

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populations. This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should: (a) Provide care that meets patient needs and respects patient preferences. (b) Avoid stereotyping patients. (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment. (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients. (e) Encourage shared decision making. (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system. The medical profession has an ethical responsibility to: (g) Help increase awareness of health care disparities. (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Racism as a Public Health Threat 350.025MSS
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies. (MSS Res. 30, I-19)

Anti-Racism Competencies in Undergraduate Medical Pre-Medical Curriculum 295.194MSS

That our AMA-MSS recognize that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; (2) That our AMA-MSS supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 011
(November 2020)

Introduced by: Abhishek Dharan, Allen Wang, Alyssa Greenwood Francis, Bryan Nguyen, Nihar Chandupatla, Texas Tech University Health Science Center El Paso; Kelsey Mumford, Dell Medical School; Jonathan Duong, Baylor College of Medicine; Kate Holder, Texas Tech University Health Science Center

Sponsored by: Region 2, Region 3

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Diabetes affects approximately 9.4% of the population and is the seventh leading cause of death nationally[1,2]; and

Whereas, Direct medical costs for diagnosed diabetes were estimated at $327.2 billion in 2017, with nearly $102 billion lost due to lower productivity resulting from diabetes[3]; and

Whereas, The annual average medical cost per person with diabetes is $13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin[4]; and

Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a Type 1 diabetic patient using an average amount of insulin (60 units per day)[5]; and

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient's prescription drug coverage plan[6]; and

Whereas, Patients who report cost-related underuse were more likely to have poor glycemic control, which is associated with an increased risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer[6,7]; and

Whereas, Seven states have approved legislation on insulin copayment caps since April 2020, instituting a $35-$100 maximum copayment for a 30-day insulin supply[8]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin prescription costs through Medicaid Part D for the 2021 plan year to a maximum $35 copay for a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%[9]; and

Whereas, Individual and family savings resulting from caps on insulin copayments have the potential to alleviate financial burden[10]; and

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Whereas, The AMA has policy consistent with the principle of increasing access to prescription medications including insulin for patients[11-16]; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan[17]; therefore be it

RESOLVED, That our AMA supports states limiting the copayments insured patients pay per month for prescribed insulin and amend current policy as shown below:

> **Insulin Affordability H-110.984**
> Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin; and (4) support limits on the copayments insured patients pay per month for prescribed insulin at a national policy level.-

Fiscal Note: TBD

Date Received: 09/20/2020

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Relevant AMA Policy

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will 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:
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;

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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 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;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will 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:
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;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports 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.

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

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.

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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.

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.

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)

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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.

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.

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.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 012
(November 2020)

Introduced by: Sarah Mae Smith, University of California-Irvine School of Medicine; Drayton Harvey, Keck School of Medicine of USC; Rohan Khazanchi, University of Nebraska Medical Center; Faith Crittenden, University of Connecticut School of Medicine; Alysa Edwards, University of Colorado School of Medicine; Lauren Matsuno, David Geffen School of Medicine at UCLA; Raveen Sugantharaj, Ayesha Quraishi, Danny Luong, Savannah Rowe, Peter Boules, Marian University College of Osteopathic Medicine; Sandra Jones, Christopher Blanco, Indiana University School of Medicine; Samantha Pavlock, Ian Motie, Florida State University College of Medicine; Miguel Devonish, Morehouse School of Medicine; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Neha Siddiqui, Carle Illinois College of Medicine; Danielle Rivera, Sally Midani, University of New Mexico School of Medicine

Sponsored by: Region 1, Region 4, Region 5, Region 6, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Subject: Policing Reform

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

I. Public health effects of police brutality

Whereas, Public awareness of police brutality has been elevated by the killings of unarmed people of color, including Michael Brown, Sandra Bland, Eric Garner, Philando Castile, Alton Sterling, Breonna Taylor, Ahmaud Arbery, George Floyd, and countless others amounting to 751 people killed by police in the United States in 2020 alone[1-6]; and

Whereas, Black Americans are three times more likely than white Americans to be killed by police and account for over 40% of victims of police killings nationwide[6-9]; and

Whereas, Police brutality and incarceration cause significant long-term spillover effects on the mental, physical, and economic health of impacted individuals, their loved ones, and their communities[10-23]; and

Whereas, Evidence shows law enforcement officers are also traumatized by participating in violence against the citizens they are tasked to protect, with higher rates of post-traumatic stress disorder, larger psychobiological stress responses, and higher rates of depression documented among officers who have had to participate in violence[24-26]; and

II. Qualified immunity maintains a system of violence impervious to reform

Whereas, Qualified immunity is a federal legal doctrine in the United States that protects law enforcement officers from civil litigation, including in cases in which they use excessive force, intended to protect officers who make mistakes in high-stress, high-paced situations[27]; and

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Whereas, In 2009, the Supreme Court ruling *Pearson v. Callahan* allowed judges to ignore the question of whether excessive force was used and decide only whether the officer's conduct was "clearly established as unlawful" and violated "clearly established" rights, a requirement that is hardly ever met in lower courts due to the need for the plaintiff to identify a previously decided case involving the exact same "specific context" and "particular conduct"[28-29]; and

Whereas, Lawyers are highly disincentivized from taking on a case against law enforcement's use of excessive force, since plaintiffs in cases dismissed on the basis of qualified immunity cannot recover fees or be appropriately compensated[28-29]; and

Whereas, Despite good intentions, qualified immunity protects the majority of law enforcement officers from ever going to trial even in cases of egregious excessive force and makes it increasingly difficult for citizens to win these cases, to the extent that 12.9% of white people and 16.8% of Black people killed by police are unarmed, but only 4% of law enforcement officers who kill people are ever charged of a crime and only 1% are ever convicted;[6,28] and

Whereas, Cases that have been dropped due to qualified immunity include a mistaken identity in which the victim was shot 17 times; an unarmed victim being smashed into a car for having a cracked windshield; and a 14-year-old boy being shot after dropping a pellet gun and raising his hands in the air, among many others[6,28]; and

Whereas, While some argue qualified immunity is necessary to protect officers from the burden of litigation, personal financial responsibilities, and potential bankruptcy, a study of more than 80 state and local law enforcement agencies across the country found that in instances of misconduct, the municipality or union, rather than individual officers, almost always paid, and another study of over 1,000 lawsuits against law enforcement officers found qualified immunity is rarely applied early enough in proceedings to protect officers from civil discovery (only 0.6 percent of the cases)[29-31]; and

Whereas, Qualified immunity has thus created a justice system that perpetuates violence as law enforcement officers who commit brutality and harassment—and the governments that employ them—have little incentive to improve their practices and follow the law given the lack of consequences[29]; and

Whereas, Since June 2020 both Colorado and Connecticut have passed legislation to eliminate qualified immunity[32-33]; and

<u>III. Militarized civil law enforcement increases risks of civilian harms</u>

Whereas, Law enforcement agencies that receive transfers of excess military equipment through the United States Department of Defense 1033 Program are increasingly militarized operationally and culturally, leading to increased violence perpetrated by law enforcement[34-35]; and

Whereas, The 1033 Program - initially enacted in 1989 for "counter-drug activities" during the War on Drugs and made permanent in 1996 with an expansion that included "counter-terrorism activities" - requires that military equipment supplied to civil law enforcement agencies be used within one year and for a minimum duration of one year, thus incentivizing use of the equipment regardless of true law enforcement need[34,36-37]; and

Whereas, Counties that do not receive military equipment have the lowest number of expected civilian deaths and violence, while those whose police departments receive military equipment

transfers through the 1033 Program are shown to have more than double the number of expected civilian deaths and incidents of violence, leading to lasting negative public health and mental health consequences in the communities where this occurs[34-35]; and

Whereas, Studies show that the number of equipment transfers to a police department through the 1033 Program positively correlates with the number of civilian casualties and the change in the number of civilian casualties from year to year[34-35]; and

Whereas, Militarization of law enforcement officers, especially without public oversight, increases fear, distrust, and alienation felt within the communities served, thereby hindering community safety; moreover, the presumption of threat held by officers increases levels of chronic stress among minority populations who are impacted by these volatile police interactions[38]; and

<u>IV. No-knock warrants contribute to increased likelihood of death and injury by law enforcement's actions</u>

Whereas, A no-knock warrant is an authorizing document with pre-search judicial approval that permits police officers to enter a home without identifying their authority or purpose beforehand, generally issued for exigent circumstances to include when entry pursuant to the knock-and-announce rule would lead to the destruction of objects for which police are searching or would compromise the safety of the police or other individual[39-40]; and

Whereas, No-knock raids place civilians and police officers at greater risk, often requiring dangerous tactics and violent escalation with devastating effects on communities, police departments, and the police-civilian relationship, as has been demonstrated by the killing of Breonna Taylor, and further, 54% of people impacted by raids conducted by paramilitary units belonged to minoritized groups[34,41-42]; and

Whereas, The success rate of no-knock raids is low with very few targets charged or sentenced to serve prison time and only 35% of targeted searches producing weapons and drugs, while victims of mismanaged no-knock raids often have little recourse to pursue compensation, reform, or legal justice given sealed documents and evidence, preference for police departments in courts, and limited review processes[34,40]; and

<u>V. Racial profiling has deleterious health effects</u>

Whereas, Racial profiling can be defined as "the act of suspecting or targeting a person of a certain race on the basis of observed or assumed characteristics or behavior of a racial or ethnic group, rather than on individual suspicion"[43]; and

Whereas, Racial profiling in the law enforcement context can be defined as the "practice of using race, ethnicity, national origin, or religious appearance as one factor, among others, when police decide which people are suspicious enough to warrant police stops, questioning, frisks, searches, and other routine police practices"[44]; and

Whereas, According to a 2018 report from the U.S. Department of Justice Bureau of Justice Statistics, Black residents are more likely to experience both street and traffic stops, Black and Hispanic residents are more likely to have multiple contacts with police, and in police-initiated interactions, Black and Hispanic residents are more likely to experience threats or use of force[45]; and

Whereas, Among multiple ethnic and racial minority groups, instances of perceived racial discrimination, particularly in the context of legal accusations, account for a modest part of the relationship between ethnic minority-majority status and poorer mental health[46]; and

Whereas, Incidents of racial profiling and police mistreatment are associated with higher levels of anxiety, depression, post-traumatic stress disorder, and suicidal ideation, particularly with more intrusive contact[43,47-48]; and

Whereas, Recent federal legislation sought to prohibit racial profiling as "the practice of a law enforcement agent or agency relying, to any degree, on actual or perceived race, ethnicity, national origin, religion, gender, gender identity, or sexual orientation in selecting which individual to subject to routine or spontaneous investigatory activities or in deciding upon the scope and substance of law enforcement activity following the initial investigatory procedure"[49]; and

<u>VI. Use of ketamine for non-medical, law enforcement purposes</u>

Whereas, Ketamine is a potent sedative used by most paramedics against people who exhibit delirious and/or agitated states, which when used inappropriately can lead to severe neurological, cardiovascular, musculoskeletal, and psychiatric complications, including delirium, rhabdomyolysis, seizures, respiratory depression, myocardial infarction and death[50]; and

Whereas, Despite ketamine's overall high level of efficacy and safe application by Emergency Department personnel, the rate of complications and the need for endotracheal intubation following administration increases when ketamine is used outside of the hospital for ground transportation[51]; and

Whereas, On August 24, 2019, 23-year-old Elijah McClain died of cardiac arrest under police custody after being administered a dose of ketamine inappropriate for his weight and medical condition, which was the most publicized case of ketamine use in Colorado out of 902 such cases between 2018 and 2020, 17% of which resulted in health complications[52]; and

Whereas, The Aurora City Council has temporarily banned the use of ketamine by first-responders for non-medically necessary law enforcement purposes as a direct result of the death of Elijah McClain[53]; and

Whereas, Law enforcement officers directing paramedics to sedate individuals using ketamine is a rising issue, with an investigation of Minneapolis police finding the number of documented ketamine injections during police calls increasing from 3 in 2012 to 62 in 2019[54]; and

Whereas, Excited delirium, for which ketamine has been increasingly used, is not recognized by the American Medical Association, is not listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is not listed in the World Health Organization's International Classification of Diseases (ICD-10), and has long been debated due to its association with acts of police brutality and disproportionate application to Black individuals[55-57]; and

Whereas, The American Society of Anesthesiologists and American College of Emergency Physicians released a joint statement in light of the killing of Elijah McClain and other such incidences stating that "the use of ketamine or any other sedative/hypnotic agent to chemically incapacitate someone solely for a law enforcement purpose and not for a legitimate medical reason" is firmly opposed by both organizations[58]; and

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VII. Trauma-informed incident responses and oversight of the use of force

Whereas, "Trauma-informed care" is a social interaction framework that requires: (a) awareness of the prevalence of trauma and its impacts on individuals' emotional, physical, and mental health; (b) recognition of the signs of trauma and how these vary demographically; and (c) avoiding retraumatization[59]; and

Whereas, There is robust research supporting law enforcement use of trauma-informed practices in the context of sexual assault as police officers are often the first people with whom survivors of sexual violence interact[60]; and

Whereas, The use and importance of trauma-informed care is more expansive than interactions with those who have experienced sexual assault, including but not limited to historical trauma in American Indian and Alaskan Native communities, childhood trauma and neglect, as well as trauma resulting from exposure to war, natural disasters, civil unrest, and gender and racially motivated violence[59,61-62]; and

Whereas, Law enforcement officers and other individuals that participate in community-based safety, such as first responders and domestic violence advocates, often lack knowledge of trauma-informed care, which has been described by the Department of Justice to result in those they interact with to be "harmed or retraumatized by insensitive, uninformed, or inadequate community and criminal justice system responses"[63]; and

Whereas, Although evidence supports the notion that disciplinary actions taken against law enforcement officers for misconduct can reduce the likelihood of repeated inappropriate behavior, only approximately 2% of allegations in Chicago are sustained, and many are dismissed because of technicalities such as a witness's failure to file an affidavit[64]; and

Whereas, The current system of police oversight allows for police officers with evident records of misconduct to continue their employment, and community oversight committees are often unable to enforce disciplinary recommendations because recommendations are often non-binding and can be dismissed by police departments[65-66]; and

Whereas, A survey by the National Association of Civilian Oversight Law Enforcement found that as of 2016, 144 community oversight committee were operating, including in almost all large and mid-size cities[67]; and

VIII. Current AMA stance on police brutality

Whereas, At the Special Meeting of the AMA House of Delegates in June, our AMA Board of Trustees released a strong pledge which denounced policy brutality and systemic, structural, institutional, and interpersonal racism[68]; and

Whereas, Existing AMA policy recognizes the need for data reporting on acts of police violence (H-515.955), school resource officer training regulation (H-60.902), and the need for the organization to speak out on law enforcement issues such as regulations around body camera use (D-160.919), but the AMA must also recognize that its push for opposing police brutality will not result in meaningful change until law enforcement officers can be held accountable for their actions and violating the very reforms supported by the AMA; therefore be it

RESOLVED, That our AMA recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; and be it further

RESOLVED, That our AMA recognize policy brutality as a threat to the physical, mental, and economic health of individuals—especially Black, Indigenous, and other people of color—their loved ones, their communities, and the police themselves; and be it further

RESOLVED, That our AMA advocate for the elimination of qualified immunity, which shields law enforcement officers from consequences for misconduct and perpetuates a system which leaves the public vulnerable to unpunishable violence; and be it further

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including abolition of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons; and be it further

RESOLVED, That our AMA advocate for the prohibition of issuance and execution of no-knock warrants; and be it further

RESOLVED, That our AMA advocate for the prohibition of utilization of racial and discriminatory profiling by law enforcement; and be it further

RESOLVED, That our AMA advocate for the prohibition of the use of ketamine and other sedative/hypnotic agents by first responders for non-medically-indicated, law enforcement purposes; and be it further

RESOLVED, That our AMA advocate for legislation and regulations which promote trauma-informed, community-based safety practices; and be it further

RESOLVED, That our AMA support the creation of community oversight committees with disciplinary power whose mission will be to decrease police-on-public violence; and be it further

RESOLVED, That this resolution be immediately forwarded to the Interim 2020 House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Police Chases and Chase-Related Injuries H-15.964
The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases. CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13.

School Resource Officer Qualifications and Training H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors. Res. 926, I-19.

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. Res. 021, A-19.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17.

Human Rights and Health Professionals H-65.981

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The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs. CSAPH Rep. 6, A-09; Modified: Res. 501, A-14.

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919
Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship. BOT Rep. 18, A-19.

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. Res. 923, I-15; Appended: Res. 220, I-18.

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives

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and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19.

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981
Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process. CSAPH Rep. 01, A-20.

Use of the Choke and Sleeper Hold in Prisons H-430.998
The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate. Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:

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1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. Res. 406, A-16; Modified: BOT Rep. 28, A-18.

Racism as a Public Health Threat 350.025MSS
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies. MSS Res. 30, I-19.

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

Improving the Intersection Between Law Enforcement and the Mentally Ill 345.008MSS
AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool for 1) educating law enforcement officers about the mentally ill, 2) diverting mentally ill offenders from jails and prisons to medical treatment centers, and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are designed to improve law enforcement’s responses to the mentally ill. MSS Res 5, A-15.

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Development of a Standardized Post-Conducted Electrical Device Exposure Medical Protocol and Educational Campaign 440.045MSS
AMA-MSS will ask the AMA to (1) encourage appropriate organizations and medical specialty societies to develop a standardized, post-exposure medical protocol for the use of conducted electrical devices (CEDs) using recent advances in the understanding of the risks associated with CEDs; and (2) support the incorporation of a standardized post-conducted electric device (CED)-exposure medical protocol into law enforcement procedures and training. MSS Res 28, I-13; Reaffirmed: MSS GC Rep A, I-19.

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

Restricting Use of Force by Law Enforcement Officers for Improved Public Health Outcomes 440.087MSS
AMA-MSS will ask the AMA to work with interested national, state and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers. MSS Res. 68, I-19.

Increased Use of Body-Worn Cameras by Law Enforcement Officers 515.011MSS
AMA-MSS will ask that our AMA advocate for legislative, administrative, or regulatory measures to expand funding for (i) the purchase of body-worn cameras and (ii) training and technical assistance required to implement body-worn camera programs. MSS Res 43, A-17.

Collecting and Releasing Data on Law Enforcement Use of Force 515.012MSS
AMA-MSS supports the collection of data by the CDC and state departments of health on serious law-enforcement-related injuries and deaths and supports making law-enforcement-related deaths a notifiable condition. MSS Res 45, A-17.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 013
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Alyssa Greenwood Francis, Texas Tech Health Sciences Center El Paso

Sponsored by: Region 4

Subject: Status of Immigration Laws, Rules, and Legislation During National Crises

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Based on results from the 2018 American Community Survey (ACS), the current undocumented immigrant population within the United States is around 10.6 million[1]; and

Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48 immigration policy changes that have affected international travel, student visas, and immigration, and asylum processes[2,3];

Whereas, During the COVID-19 pandemic, immigration processing has been nearly halted both overseas and domestically, setting a precedent for future national crises[3]; and

Whereas, Changing rules in immigration courts during the COVID-19 pandemic caused significant confusion for immigration lawyers, for example, in Dallas where three different immigration judges issued three conflicting rulings on immigration law proceedings[4]; and

Whereas, The suspension of the United States Custom and Immigration Services (USCIS) during the COVID-19 pandemic has led to a back-up in the processing of necessary documentation, which has left many unable to access certain benefits necessary for work, receiving healthcare, and accessing public benefits[5]; and

Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-detained individuals on March 18, 2020, which delayed the processing of asylum seekers enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary conditions that promotes the spread of the virus[5]; and

Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both entry at the northern and southern borders and barred asylum seekers from entering the country due to public health threats[5]; and

Whereas, The World Health Organization (WHO) has previously stated, “In general, evidence shows that restricting the movement of people and goods during public health emergencies is ineffective in most situations and may divert resources from other interventions”[5]; and

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Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed hearings for detained people, prolonging their stay in detention centers[4,5]; and

Whereas, Immigrations and Customs Enforcement (ICE) admitted that virus mitigation efforts such as social distancing are likely not possible in their detention facilities, in addition to providing unsanitary conditions prior to the pandemic[6]; and

Whereas, The relief packages that were provided by the government during the pandemic either provided little or no coverage to immigrants and their families, leaving them with few options for testing and treatment[5,7]; and

Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19 related services available under emergency Medicaid, which means that immigrants are unable to access these services since they cannot apply for non-emergency Medicaid due to immigration eligibility criteria[1,5,8]; and

Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive unemployment insurance or government stimulus checks during national crises[5,9]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to receive a stimulus payment to individuals with a social security number, which limits many immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)[1,5,8]; and

Whereas, By not allowing ITIN tax filers to receive economic assistance from the federal government, around 5.1 million children were excluded from benefiting from the provisions of the CARES act[1]; and

Whereas, Lapses in work authorization due to slowed processing times and suspension of required processing services may result in immigrants being unemployed or losing benefits offered by their employer[5,8]; and

Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI) programs, but due to lapses in work authorizations, many immigrants may either not qualify or lose access to this vital benefit[1]; and

Whereas, Eligibility for emergency medical benefits are state-determined and only one state, New York, expanded these benefits to cover COVID-19 testing and treatment for immigrants[9]; and

Whereas, Uncertainty surrounding shifting immigration enforcement legislation led to undocumented immigrants being reluctant to seek health care for COVID-19 symptoms, worsening community spread of the virus[9]; and

Whereas, Previous immigration law changes, such as the rollout of the February 24, 2020 Public Charge rule, which penalizes immigrants for using public assistance like Medicaid, mislead countless immigrant parents to remove their U.S. citizen children from health care insurance, likely leading to unnecessary child morbidity and mortality[9,10]; and

Whereas, A previous study before the implementation of the final Public Charge rule, found that this rule would cause a “chilling effect,” leading to decreased utilization of public assistance and health care services, even for families who have children covered under federal programs[10]; and

Whereas, A Well-Being and Basic Needs Survey conducted in December 2018 found that, "About one in seven adults in immigrant families (13.7 percent) reported "chilling effects," in which the respondent or a family member did not participate in a noncash government benefit program in 2018 for fear of risking future green card."[5,11]; and

Whereas, Decreased participation in public benefit programs would contribute to a greater uninsured population, a decrease in the use of both preventive and curative health services, and negatively affect the health outcomes and financial stability of nearly 22 million noncitizens currently residing in the U.S.[12,13,14]; and

Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the COVID-19 pandemic would not count as a public charge[15,16]; and

Whereas, As of July 29, 2020 another two lawsuits have been filed against this ruling and it has since been held up from being enacted further[15,16]; and

Whereas, A focus group of 100 immigrant families with children found that many families report an increased level of fear and decreased utilization of health care services due to fear of deportation, regardless of current immigration status[17]; and

Whereas, Increased fear of deportation among families, even if only one family member is a non-citizen immigrant, not only causes decreased health care utilization but also causes increased behavioral issues in children[17]; and

Whereas, Current AMA policy establishes the precedent that our AMA will act on behalf of the health of immigrants, refugees, migrant workers, and asylum seekers (H-350.957 Addressing Immigrant Health Disparities), which has lead the AMA to be outspoken on various immigration policy changes during the COVID-19 pandemic, although they have not taken action on all of these changes; therefore, be it

RESOLVED, In order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic, our AMA:

(1) opposes the slowing or halting of immigration processing, courts, or decisions that might unnecessarily prolong detention of individuals and families
(2) opposes continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance during national crises that impose a health risk
(3) supports the extension of work authorization regardless of immigration status if a national crisis causes the halting of immigration processing
(4) opposes eligibility restrictions, such as those for enrollment in Medicaid, that would hinder immigrants, refugees, migrant farm workers, and asylum seekers from accessing adequate health care
(5) supports the ability of immigrants, refugees, migrant farm workers, and asylum seekers who utilize Individual Taxpayer Identification Numbers (ITIN) to pay taxes to be able to receive economic assistance the federal government allocates through emergency relief bills designed to alleviate taxpayer financial stress
(6) opposes the federal government utilizing public health concerns as a false threat to national security to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international

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medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. (Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19)

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

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities. (Res. 004, I-18)

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. (Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19)

HIV, Immigration, and Travel Restrictions H-20.901

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Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18)

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19)

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS
AMAMSS will ask the AMA to (1) upon the release of any proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and (2) amend AMA policy H-20.901 by addition and deletion to read as follows: HIV, Immigration, and Travel Restrictions H-20.901 Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (MSS Res 01, A-18) (AMA Res. 254, A-18, Adopted [D-440.927])

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and wellbeing of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 014
(November 2020)

Introduced by: Khalid N Sheikh; Urvashi Mathur; Sahar Panjwani, University of Texas Rio Grande Valley School of Medicine; Christopher Pardo; Creighton University School of Medicine - Phoenix Campus; Brittany Wagner; Julia Cucarola, Louisiana State University Health Science Center at Shreveport School of Medicine; Justin T. White, University of Louisville School of Medicine; Sanjay Jinka; Krithika Sundaram, Northeast Ohio Medical University; Shyon Parsa, University of Texas Southwestern Medical School.

Sponsored by: Region 2, Region 3, Region 5

Subject: Medicaid and Children's Health Insurance Program (CHIP) Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Type 1 and type 2 diabetes pose large and steadily increasing health threats for both adults and youth in the United States, with approximately 26.8 million adults and 210,000 youth under the age of 20 currently diagnosed with one of the diseases[1–6]; and

Whereas, Medicaid and Children's Health Insurance Program (CHIP) are currently the primary public health insurance programs in the United States, with over 73 million Americans currently enrolled in either program[7]; and

Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of diabetes[8]; and

Whereas, Great variability exists between states for CHIP eligibility and coverage, with some states providing less coverage to program participants than others[9]; and

Whereas, The total cost of diagnosed diabetes in 2017 was estimated to be 327.2 billion dollars due to excess medical expenditures and lost work productivity[10]; and

Whereas, Annual health care expenditures in 2017 for people with diabetes were 2.3 times higher ($16,752 vs $7,151) compared to expenditures for people of similar age and sex without diabetes, suggesting diabetes is responsible for an estimated $9,600 in excess expenditures per year per person with diabetes[4]; and

Whereas, Continuous Glucose Monitoring (CGM) is a diabetes management technology that allows users to track glucose levels in real-time and has been shown to significantly improve glycemic control among adult and pediatric patients with insulin-dependent type 1 and type 2 diabetes[11–16]; and

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Whereas, CGM has been demonstrated to detect hypoglycemic and hyperglycemic episodes in patients with gestational diabetes mellitus and may improve maternal and fetal outcomes[17]; and

Whereas, CGM use has been demonstrated to both reduce the cost of diabetes and be likely cost-effective despite its initial cost by minimizing costly hospitalizations due to hypoglycemia and other complications in patients with diabetes[18–23]; and

Whereas, CGM use has been demonstrated to to improve patients' quality of life, reduce fear of hypoglycemia, and provide a sense of empowerment to patients and their caregivers[24–26]; and

Whereas, The high cost of CGM devices prohibits many patients from affording the devices and may be a factor contributing to disparities of CGM use among minority patients and patients with public insurance[27-28]; and

Whereas, The cost of diabetes supplies including CGMs is relatively small, accounting for only 1.1% of the total cost of diabetes, while the cost of potentially reducible complications and decreased productivity accounts for 73.1% of national diabetes costs[29]; and

Whereas, As of 2019, only 4 states provide full coverage of CGM for adult and pediatric patients with insulin dependent diabetes through Medicaid and 14 states provide no coverage, thereby preventing patients from benefiting from these devices[29]; and

Whereas, An estimated 38% of patients with type 1 diabetes currently use CGM and estimates on patients with insulin-dependent type 2 diabetes are unavailable but likely lower[30]; and

Whereas, Current AMA policy through H330.885 supports coverage of CGM for Medicare patients with insulin-dependent diabetes but does not address Medicaid or CHIP; and

Whereas, Medicaid and public state medical insurance expansions that include CGM devices have been demonstrated to improve glycemic control and reduce disparities in pediatric patients with type 1 diabetes[31-32]; therefore be it

RESOLVED, That the AMA amend Resolution H-330.885 to include the following:

> **Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885**
>
> Our AMA supports efforts to achieve Medicare, <u>Medicaid, and Children's Health Insurance Program (CHIP)</u> coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

1. Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. Res. 126, A-14

Diabetic Documentation Requirements D-185.983

1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care

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insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies.
2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.

Increasing Access To Medical Devices for Insulin-Dependent Diabetics 180.017MSS

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

MSS Res 27, I-15: MSS formally established support for H-330.885

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 015
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Brittany Ikwuagwu, McGovern Medical School

Sponsored by: Region 3

Subject: Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The USDA Food and Nutrition Service (FNS) administers 15 federal nutrition-assistance programs across the country[1]; and

Whereas, The National School Lunch Program (NSLP) and the School Breakfast Program (SBP), provide vital sources of food for low-income children during the school year[1]; and

Whereas, In the 2018-19 school year, the NSLP, which had a $12.5 billion budget in 2016, served 4.9 billion lunches to 29.6 million children around the country, and the SBP served 2.5 billion breakfasts to 14.8 million children[1,2]; and

Whereas, The U.S. Department of Agriculture (USDA) National School Lunch Program, School Breakfast Program, and Child and Adult Care Food Program serve nearly 35 million children daily[3]; and

Whereas, Children living with families whose incomes are at or below 130 percent of the federal poverty level (currently $26,200 for a family of four) are eligible for free meals, and those with incomes between 130 and 185 percent of the federal poverty level are eligible for reduced-price meals[1,2]; and

Whereas, Children automatically qualify for free meals if their household participates in the Supplemental Nutrition Assistance Program (SNAP), and they may be matched through other programs, such as the Temporary Assistance for Needy Families cash assistance program or the Food Distribution Program on Indian Reservations[1]; and

Whereas, Schools and school districts that have at least 40 percent of students deemed automatically eligible for free lunch may participate in the Community Eligibility Provision (CEP), which allows schools to serve universal free meals without collecting household applications[1]; and

Whereas, CEP allowed more than 13.6 million students in more than 28,000 schools to receive free lunch in the 2018–19 school year[1]; and

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Whereas, Based on an online survey (n=584), pick-up school-provided meals during the pandemic were received by 40.0% of families, while 27.8% received SNAP benefits, 11.7% received WIC benefits, and 16.5% received meals from local food banks or food assistance programs[4]; and

Whereas, The COVID-19 pandemic contributed to a 17% overall decrease in the percentage of food secure families, while the overall percentage of families experiencing very low food security increased by 20%[4]; and

Whereas, Food insecurity is negatively associated with health outcomes, including poor mental health outcomes such as depression, stress, and anxiety, poor diet quality, high rates of chronic diseases such as diabetes and obesity, and a lower overall health status[5]; and

Whereas, The COVID-19 pandemic, and the associated social and economic responses have the potential to dramatically increase food insecurity and its related health disparities among already at-risk populations[5]; and

Whereas, Studies have shown that the United States' food system is not resilient against the expected level of worker unemployment during a pandemic. With the unprecedented rise in U.S. unemployment rate, and the fact that rates of food insecurity parallels unemployment and economic trends, food insecurity is predicted to climb higher as the pandemic progresses[5,6]; and

Whereas, Around 60.1% of families experienced a decrease in income during the pandemic, 23.4% of which were low food secure and 42.5% were very low food secure[4]; and

Whereas, Families that were already experiencing food insecurity before COVID-19 are more likely to have worsened insecurity during the pandemic, specifically 46.5% of these families experienced very low food security during this time[4]; and

Whereas, Individuals with low or very low food security are more likely to be non-Hispanic Black or Hispanic, be of lower socioeconomic status, have children in the home, not have health insurance or have Medicaid, and are more likely to be receiving SNAP benefits[7]; and

Whereas, This racial disparity in food security status is yet another example in which COVID-19 is disproportionately impacting minority and other marginalized communities in the United States[7]; and

Whereas, In comparison with 8% of white students, 45% of African American and Hispanic children attended high-poverty schools, where ≥75% of the student population have free or reduced-price lunch eligibility[8]; and

Whereas, Some solutions that have been enacted in order to provide meals for students that are not physically attending school have included waivers for school districts, such as allowing schools to serve meals outside of their standard times, that allow for expansion of normal meal assistance programs[1]; and

Whereas, The increased need for meals and short time constraint of the pandemic have led to decreased reimbursement rates per meal, which only exacerbates the increased cost of these programs caused by staffing and delivery difficulties[1]; and

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Whereas, Some school districts offer the Summer Food Service Program (SFSP) and the Seamless Summer Option (SSO), which are typically used to continue serving meals to children during unanticipated school closures[1]; and

Whereas, Despite various efforts to provide access to meals for families and children not at school, only 11% of newly unemployed families were reporting access to “grab-and-go” meals during the pandemic[9]; and

Whereas, The Pandemic Electronic Benefit Transfer (P-EBT) program was reauthorized in the Families First Coronavirus Act, and enables states to enact emergency standards of eligibility for children who have lost access to free- or reduced-price meals because their schools closed for at least five consecutive days in response to the COVID-19 pandemic[1]; and

Whereas, The P-EBT program provides households for whom schools are closed for 20 days in a month a total benefit of $115.60 per child[1]; and

Whereas, Certain restrictions that exist for those using federal meal benefits, such as purchasing restrictions, may lead to decreased ability to purchase certain types of food or purchase food through some means[10]; and

Whereas, Available programs and offerings that the federal government have put in place have not been widely or equally adopted by states, leading to exacerbation of disparities on a geographical basis[10]; and

Whereas, Shifting the main responsibility of providing nutrition to children to the SNAP program may have negative health implications, since SNAP does not adhere to strict nutrition guidelines in the same ways that school meal programs must[3]; and

Whereas, There has not been a mandate released by the USDA to offer food service during school closures or for students who are not physically present at schools[3]; and

Whereas, The United States Food and Nutrition Service (FNS) released a statement that reaffirmed their commitment to allowing states to serve free meals to children, launching Pandemic-EBT (P-EBT), increasing SNAP benefits, addressing supply challenges, providing billions of dollars in food through local food banks, food pantries, and disaster household distributions, and approving nearly 3,000 flexibilities and program adjustments to ease operations and protect the health of applicants and participants[11]; and

Whereas, Previous AMA policies established precedent for the AMA’s support of healthy meals and the availability of nutrition through school lunch programs for children (AMA Policies H-150.962 and H-150.937); therefore, be it

RESOLVED, That our AMA amend policy H-150.962, Quality of School Lunch Program, by addition as follows:

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.

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2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
3. Our AMA advocates for increased funding and governmental assistance for both federal and state level nutrition and meal assistance programs, including viable alternatives to these programs, during national crises, such as a pandemic.
4. Our AMA will work with state medical associations to encourage all states, counties, and school districts to adopt programs that provide meals during national crises, such as a pandemic.

;and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Quality of School Lunch Program H-150.962
1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

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

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.
Res. 921, I-18

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.
Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

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

Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research 150.036MSS

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

Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S. 150.040MSS
AMA-MSS supports evidence-based methods of addressing food insecurity. (MSS CGPH Report A, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 016
(November 2020)

Introduced by: Rohan Khazanchi, University of Nebraska Medical Center; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Ellena Popova, University of Pennsylvania; Alec Calac, University of California, San Diego; Angela Y. Zhang, Warren Alpert Medical School of Brown University

Sponsored by: Region 1, Region 2, Region 4, Region 6, Region 7, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Subject: Denouncing Racial Essentialism in Medicine

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, At the turn of the twentieth century, sociologist and civil rights leader W.E.B. DuBois synthesized sociological and scientific evidence to conclude that race is not a scientific category, and rather that racial health disparities stemmed from social, not biological, inequalities[1]; and

Whereas, “Racial essentialism” is defined as the belief in a genetic or biological essence that defines all members of a racial category[2–4]; and

Whereas, The modern scientific consensus is that race is a social construct based on prevailing societal perceptions of physical characteristics, and that there are no underlying biological traits that unite people of the same racial category[3–14]; and

Whereas, Race as a variable has been inconsistently defined in research literature, clinical practice guidelines, and even U.S. Census categorizations[5,7,11–13,15–21]; and

Whereas, Race is often inappropriately conflated with ethnicity, which led to passage of AMA policy recognizing that race and ethnicity are conceptually distinct (H-460.924)[7,14,15,22]; and

Whereas, Decades of rigorous genetics research has confirmed that genetic and biological variation exists within and among populations across the planet, and groups of individuals can be differentiated by patterns of similarity and difference, but these patterns do not align with socially-defined racial groups (e.g., white, Black) or continentally-defined geographic ancestral clusters (e.g., Africans, Asians, and Europeans)[4–10,12,15,22]; and

Whereas, Many clinical calculations that “correct for race” were developed under the mistaken belief that race is a useful proxy for intrinsic biological or genetic traits[10,12,13];and

Whereas, Spirometric pulmonary function tests (PFTs) guidelines currently recommending a race-based correction factor despite a 2013 literature review demonstrating that 94% of articles

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comparing PFTs between white and non-white groups do not assess confounders like socioeconomic status[13,16,17,23]; and

Whereas, Current literature demonstrates that use of race in clinical score calculators is unnecessary, less precise than biological measures, and leads to results that are not reproducible, as evidenced by the use of race in the calculation of estimated glomerular filtration rate (eGFR) based on a 1999 study of 1,628 patients (only 12% of whom self-identified as "Black")[13,18–20,24,25]; and

Whereas, Because the use of race in clinical algorithms reifies racial essentialism and can disproportionately harm Black patients, leading institutions around the country have discarded race-based reporting of eGFR and key stakeholders in the nephrology field are actively working to eliminate this practice in lieu of non-race-based alternatives[12,18–20,26–30]; and

Whereas, Clinical tests and criteria that use race-based factors often do not account for the existence of people from multiracial backgrounds, a population that now makes up 14% of infants born in the US, and other underserved populations including American Indians and Alaskan Natives[12,21,31]; and

Whereas, Current AMA policy supports "research into the use of methodologies that allow for multiple racial and ethnic self-designations" and encourages applying research evidence on race, ethnicity, and health to "the planning and evaluation of health services" (H-460.924); and

Whereas, Perpetuating the incorrect belief that race by itself can explain biological variation contributes to tangible inequities, such as the undertreatment of pain due to wrongly perceived biological differences in pain tolerance, delays in referral for renal transplantation, under-referral for DEXA scans, industry denial of worker's compensation, and more[10,12,13,20,32–35]; and

Whereas, Although racial essentialism is harmful and has no scientific validity, teaching trainees about and researching race as a sociopolitical construct is useful to understand structural racism as a root cause of health inequity, the lived experiences of patients which contribute to their relationship with the healthcare system, and the day-to-day experiences which affect individual health outcomes[3,9–11,36–41]; and

Whereas, Since race and racism impact multiple structural determinants of health, there is no easy replacement risk factor, which highlights the need for directed research to uncover the true causal pathways mitigating racial differences in disease prevalence and health outcomes[9,10,19,20,22,39–42]; and

Whereas, Our AMA denounces practices which exacerbate health disparities, serves as a leading voice for marginalized minority groups, and "encourages investigators to recognize the limitations of current methods for classifying race" (H-65.963, H-460.924), but current policy does not identify or explicitly discourage the inappropriate practice of using race as a proxy for biological risk factors; and

Whereas, Our AMA-MSS recognizes that structural racism and systemic discrimination are distinct from interpersonal discrimination and implicit bias (295.194MSS); and

Whereas, Our AMA-MSS will be bringing a resolution to the A-20 House of Delegates that asks the AMA to identify current best practices that recognize and address the health effects of

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racism (350.025MSS), which notably could include explicitly addressing racial essentialism in medical education and clinical practice; and

Whereas, At the Special Meeting of the AMA House of Delegates in June 2020, our AMA Board of Trustees publicly recognized racism as an urgent threat to public health and resolved to "actively work to dismantle racist and discriminatory policies and practices across all of health care"[43]; therefore be it

RESOLVED, Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, other appropriate stakeholder organizations, and content experts to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, Our AMA will issue a position statement on the first two Resolved clauses; and be it further

RESOLVED, Our AMA will report back to the House of Delegates at I-21 on the status of the third and fourth Resolved clauses; and be it further

RESOLVED, Given the timely nature of national conversations on this issue, our AMA-MSS will immediately forward this resolution to the I-20 AMA House of Delegates.

Fiscal note: TBD

Date received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY:

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that:
(1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision Res. 602, I-15

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

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B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.
Res. 405, A-18

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Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; (3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and (4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.
Res. 409, A-09; Appended: Res. 416, A-11

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;

(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Res. 914, I-07; Modified: BOT Rep. 22, A-17

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

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

350.025MSS Racism as a Public Health Threat: AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies.
(MSS Res. 30, I-19)

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295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum: That our AMA-MSS recognize that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; (2) That our AMA-MSS supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation.
(MSS Res 74-I-17)

350.020MSS Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities: AMA-MSS will ask the AMA to: (1) amend H-315.996 by insertion to read as follows: Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records H-315.996: The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and (2) encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.
(MSS Res 74-I-17)

295.193MSS Implicit Bias and Its Effects on Healthcare and Its Incorporation into Undergraduate Medical Education: That our AMA-MSS recognizes the existence of implicit bias among health care clinicians; and be it further (2) That our AMA-MSS recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and be it further (3) That our AMA-MSS support medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients.
(MSS Res 07, I-17)

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 017
(November 2020)

Introduced by: Clara Liu, Kansas City University of Medicine and Biosciences; Neha Siddiqui, Carle Illinois College of Medicine; Jennifer Gaertner-Otto, University of the Incarnate Word School of Osteopathic Medicine; Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Arvinth Sethuraman, Rutgers University New Jersey Medical School; Abirami Rajasegaran, Texas Tech University Health Sciences Center School of Medicine; Julia Seiberling, University of California Riverside; Imaima Casubhoy University of Missouri Kansas City School of Medicine; Manasa Melachuri, Northeast Ohio Medical University

Sponsored by: N/A

Subject: Decriminalization of Physicians Who Provide Abortion Procedures

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In recent years, physicians who choose to provide medical abortions are being criminalized in new anti-abortion laws, which act on a local, state, and regional level, discouraging those who choose to perform the procedure under necessary medical care (past AMA policy H-160.954); and

Whereas, During the COVID-19 pandemic, states such as Texas have declared abortions to be non-essential procedures, effectively banning abortions and keeping physicians from performing a time-sensitive procedure, in addition to legislating over physician autonomy to practice based on medical judgement and conscience; and[3]

Whereas, ACOG declared abortions to be essential and time-sensitive procedures, and therefore physicians should be allowed to practice abortions, including during national emergencies; and[4]

Whereas, Legal abortion services provided by trained physicians have been recognized as a safe medical practice by the National Academies of Science, Engineering and Medicine; and[13]

Whereas, Ohio's "Heartbeat Bills" (senate bills 208, 538) criminalize physicians who carry out abortion procedures or attempt to perform an abortion, with Alabama, Missouri, and Texas following Ohio in legally condemning physicians who perform abortions; and[5, 6, 7, 8, 9, 10, 11]

Whereas, There is significant concern that criminalization of abortions will decrease the number of OB/GYNs that practice in a restrictive state, and affect surrounding regions, leaving these areas with a lack of comprehensive reproductive healthcare; and[10]

Whereas, Physicians have been advised by colleges to stop practicing medicine in their respective community, state, or region if they are found to be abortion providers; and[14]

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Whereas, Physicians could potentially lose their medical licenses as a result of recent anti-abortion laws; and[14]

Whereas, Ohio and North Dakota lawmakers attempted to legislate physicians into providing information about “abortion pill reversal,” an unproven concept which misleads patients with incorrect medical information; and[2, 8]

Whereas, More anti-abortion laws have been enacted within recent years, which limits physicians who elect to practice safe abortions; these laws go against our AMA’s stance that “abortion is a medical procedure and should be performed... in conformance with standards of good medical practice and the Medical Practice Act of his state” (past AMA policy H-5.995); and
Whereas, Our AMA opposes violence and all acts of intimidation directed at physicians and medical facilities, including abortion clinics and family planning centers (past AMA policy H-5.997, 5.002-MSS, 5.003-MSS); and

Whereas, Our AMA opposes criminalization of patients who elect to have an abortion, but patients are currently facing shortages of abortion providers, in regions such as the southeast United States, leaving limited options for safe and legal abortions (past AMA policy H-5.980); and[1]

Whereas, Several current AMA policies conflict with anti-abortion state legislation; H-5.989, H-160.954, and H-160.946 oppose government interference of physician autonomy and patient-physician relationship, while certain state laws oppose and/or limit good medical practice and physician conscience (H-5.993, H-5.995); and

Whereas, Our AMA opposes legislative use of funding mechanisms to deny abortion services, but does not yet oppose legislative criminalization of medical practice as a way to deny abortion services (H-5.998); and

Whereas, Current AMA policy does not include local, state, or regional sanctions in existing policies, rather only opposing interference by federal government and third parties (AMA existing policy H-5.989) and involvement of federal legislation by defining “appropriate medical practice and regulate[s] such practice through the use of criminal penalties” (past AMA policy H-160.954); and

Whereas, This legislation does not require that the AMA take a stance on abortion, as our AMA protects OB/GYNs who are morally opposed to performing abortions; rather we call for the implementation of policy to protect physicians who choose to provide necessary abortion procedures (past AMA policy H-5.990); and

Whereas, Our AMA supports physicians’ autonomy by protecting physicians from legal action, preventing legal/institutional interference in the patient-provider relationship, and opposing initiatives that prevents physicians from acting in accordance with their morals or scope of practice (past AMA policy 1.1.7, CoE 1.1.7); and

Whereas, Our AMA supports optional medical training for medical students, residents, and physicians who choose to learn abortion procedures, but does not mandate abortion training on those opposed (past AMA policy H-295.923); and

Whereas, Our AMA has opposed recent legislation regarding abortion care that directly interferes with healthcare decision-making on the basis of H-160.946, however this current AMA policy does not protect the actual practice of abortion, and is therefore not sufficiently in opposition of recently passed criminal laws against physicians who perform abortions; and[2]
Whereas, Current AMA policy does not address local, state, or regional sanctions, rather only stating opposition of "any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both," and "any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States" (past AMA policy H-373.995); and

Whereas, Our intent is not to change current abortion practice guidelines (past AMA policy H-5.982), but grant autonomy and protection of physicians who elect to perform abortions as an act of essential medical care; therefore be it

RESOLVED, The AMA opposes local, state, and regional sanctions and interference in the criminalization of or any other legal repercussions for physicians who perform essential reproductive care and family planning services, including, but not limited to, contraceptive care, emergency care for miscarriages, infertility treatments, voluntary sterilization, or the induction of miscarriage; and be it further

RESOLVED, That our AMA amends policy H-5.993, Right to Privacy in Termination of Pregnancy, H-5.995, Abortion, 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

> **Right to Privacy in Termination of Pregnancy, H-5.993**
> "The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice ~~and the laws of the state~~; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles";

; and be it further

RESOLVED, That our AMA amends policy H-5.995, Abortion, 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

> **Abortion, H-5.995**
> "Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice ~~and the Medical Practice Act of his state~~; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles";

; and be it further

RESOLVED, That our AMA amends policy 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

> **Abortion, AMA Principles of Medical Ethics, 4.2.7**
> "The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice ~~and under circumstances that do not violate the law~~."

; and be it futher

RESOLVED, That our AMA amends policy H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

> **The Criminalization of Health Care Decision Making, H-160.946**
> "The AMA opposes the attempted criminalization of health care decision-making and practice, especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and practice and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making and practice."

; and be it further

RESOLVED, That our AMA amends policy H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

> **Public Funding of Abortion Services, H-5.001MSS**
> "(2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to local, regional, and state legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding."

; and be it further

RESOLVED, That our AMA amends policy H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Criminalization of Medical Judgement, H-160.954
"(2) Henceforth our AMA opposes any future legislation which gives the federal, regional, state, or local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties."

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Public Funding of Abortion Services, H-5.998
The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. Sub. Res. 89, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: BOT Rep. 12, A-05 Reaffirmed: CMS Rep. 1, A-15

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

Patient-Physician Relationships, Code of Medical Ethics 1.1.1
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. Issued: 2016

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

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(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

Right to Privacy in Termination of Pregnancy, H-5.993
The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities. Res. 49, I-89 Reaffirmed by Sub. Res. 208, I-96 Reaffirmed by BOT Rep. 26, A-97 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: CCB/CLRPD Rep. 2, A-14

Abortion, Code of Medical Ethics 4.2.7
The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law. Issued: 2016

Abortion, H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. Sub. Res. 43, A-73 Reaffirmed: I-86 Reaffirmed: Sunset Report, I-96 Reaffirmed by Sub. Res. 208, I-96 Reaffirmed by BOT Rep. 26, A-97 Reaffirmed: CMS Rep. 1, I-00 Reaffirmed: CEJA Rep. 6, A-10

Medical Training and Termination of Pregnancy, H-295.923
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the

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requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.
Res. 315, I-94 Reaffirmed: CME Rep. 2, A-04 Modified: CME Rep. 2, A-14 Modified: CME Rep. 1, A-15 Appended: Res. 957, I-17

Violence Against Medical Facilities and Health Care Practitioners and Their Families, H-5.997
The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers. Res. 82, I-84 Reaffirmed by CLRPD Rep. 3 - I-94 Res. 422, A-95 Reaffirmation I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

Freedom of Communication Between Physicians and Patients, H-5.989
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. Sub. Res. 213, A-91 Reaffirmed: Sub. Res. 232, I-91 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmed by Sub. Res. 133 **and** BOT Rep. 26, A-97 Reaffirmed by Sub. Res. 203 **and** 707, A-98 Reaffirmed: Res. 703, A-00 Reaffirmed in lieu **of** Res. 823, I-07 Reaffirmation I-09 Reaffirmation: I-12 Reaffirmed in lieu **of** Res. 5, I-13

Policy On Abortion, H-5.990
The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. Res. 158, A-90 Reaffirmed by Sub. Res. 208, I-96 Reaffirmed by BOT Rep. 26, A-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: Res. 1, A-09 Reaffirmed: CEJA Rep. 03, A-19

The Criminalization of Health Care Decision Making, H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making. Sub. Res. 202, A-95 Reaffirmed: Res. 227, I-98 Reaffirmed: BOT Rep. 2, A-07 Reaffirmation A-09 Reaffirmation: I-12

Government Interference in Patient Counseling, H-373.995

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1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
   A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
   B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
   C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
   D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
   E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
   F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
   G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Res. 201, A-11 Reaffirmation: I-12 Appended: Res. 717, A-13 Reaffirmed **in** lieu of Res. 5, I-13 Appended: Res. 234, A-15 Reaffirmation: A-19

Oppose the Criminalization of Self-Induced Abortion, H-5.980
Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion. Res. 007, A-18

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Criminalization of Medical Judgment, H-160.954
(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. Sub. Res. 223, I-93 Reaffirmed: Res. 227, I-98 Reaffirmed: Res. 237, A-99 Reaffirmed and Appended: Sub. Res. 215, I-99 Reaffirmation A-09 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation: I-12 Modified: Sub. Res. 716, A-13 Reaffirmed in lieu of Res. 605, I-13

Physician Exercise of Conscience, 1.1.7
Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
(d) Be mindful of the burden their actions may place on fellow professionals.
(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

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(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.
Issued: 2016

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

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

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

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand **termination** of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.
BOT Rep. 26, A-97 Modified and Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: CSAPH Rep. 01, A-17

Condemnation of Violence Against Abortion Clinics, 5.002-MSS
AMA-MSS will ask the AMA to condemn the violence directed against abortion clinics and family planning centers as a violation of the right to access health care. AMA Amended Res 82, I 84, Adopted [H-5.997] Reaffirmed: MSS COLRP Rep B, I-95 Reaffirmed: MSS Rep B, I-00 Reaffirmed: MSS Rep E, I-05 Reaffirmed: MSS GC Rep F, I-10 Reaffirmed: MSS GC Rep D, I-15

Patient Confidentiality and Reproductive Health, 5.003-MSS

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AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion. MSS Amended Res 11, A-04 Reaffirmed: MSS GC Report A, I-16

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 018
(November 2020)

Introduced by: Jerome Soldo, University of Louisville School of Medicine; Joey Whelihan, University of Florida College of Medicine; Haidn Foster, University of Cincinnati College of Medicine.

Sponsored by: Region 1, Region 4, Region 5, Region 7

Subject: Gender-Neutral Language in AMA Policy

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Existing AMA policy inconsistently uses gendered language- in particular, gender pronouns- when referring to physicians, medical students, patients, and others, most often referencing generic individuals with traditionally male and sometimes female pronouns ("he/him/his", "he or she", "his or hers"); and

Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states "Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients…"; and

Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current U.S. medical students are women, and there many medical students and physicians who have other genders that are not male or female, including gender-expansive, gender-fluid, gender-nonconforming, genderqueer, nonbinary, and others[1,2,7]; and

Whereas, The frequent default use of male pronouns to describe generic physicians in AMA policy (for example, using "him" and "his" as pronouns for "the physician") may reinforce patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such pronouns[3-6]; and

Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing that American physicians and the patients we serve have diverse gender identities and may use similarly diverse personal pronouns; and

Whereas, One solution for correcting the bias established by using traditionally male pronouns as default in AMA policy is to replace them with gender-neutral pronouns such as "they", "them", "their", and "theirs", which are pronouns used by many gender non-binary individuals and may also be used to collectively describe people of all genders[7]; and

Whereas, The pronouns "they", "them", "their", and "theirs" have long been widely accepted as both singular and plural pronouns, allowing them to be incorporated into AMA policy with great flexibility[8-10]; and

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Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into AMA policy would be an efficient and adequate way to collectively reference medical students, physicians, patients, and others of all genders; and

Whereas, Updating the language in our AMA's policies to be maximally inclusive is a simple act that aligns with our organization's work to document and appreciate the diversity in sexual orientation and gender identity (SOGI) of our members as well as to champion gender equity and non-discrimination in medicine and society[11-16]; and

Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future language relating to LGBTQ people, establishes precedent for this timely action; therefore be it

RESOLVED, That our AMA (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears; (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used.

Fiscal Note: TBD

Date Received: 08/02/2020

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RELEVANT AMA AND AMA-MSS POLICY

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

Principles for Advancing Gender Equity in Medicine H-65.961
Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

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5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974
Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment G-600.067
Our AMA will: (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; (3) present the preliminary study results to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and (4) produce a report within 18 months with study results and recommendations.

Utilization of "LGBTQ" in Relevant Past and Future AMA Policies D-65.990
Our AMA will: (1) utilize the terminology "lesbian, gay, bisexual, transgender, and queer" and the abbreviation "LGBTQ" in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation "LGBTQ" in place of the abbreviations "LGBT" and "GLBT" where such text appears; and (3) revise all relevant

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and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer” to replace “lesbian, gay, bisexual, and transgender” where such text appears.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 019
(November 2020)

Introduced by: Rajadhar Reddy, Mary Robichaux, Baylor College of Medicine; Samantha Pavlock, Florida State University College of Medicine

Sponsored by: Region 1, Region 3, Region 4, Region 6, Region 7

Subject: Support for Mental Health Courts

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, "Mental health courts" are correctional diversion and rehabilitation programs used by state and local courts to support individuals with mental illness in the justice system[1-7]; and

Whereas, Mental health courts connect individuals with mental illness to mental health treatment, as an alternative to incarceration or other legal sentences and penalties[1-7]; and

Whereas, Two pieces of federal Congressional legislation, the America's Law Enforcement and Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and resources in the justice system and to establish grants to fund mental health court programs[8-9]; and

Whereas, The continued funding of MIOTCRA programs over the last two decades has been dependent on Congressional appropriations[10]; and

Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA) in the Department of Justice administer grants to fund state and local mental health courts[11,12]; and

Whereas, Research demonstrates that mental health courts appear to be associated with reductions in recidivism, length of incarceration, severity of charges, risk of violence, and rehospitalization among individuals with mental illness in the justice system[3,13-26]; and

Whereas, SAMHSA published a 2015 report noting that because "the vast majority of individuals who come into contact with the criminal justice system appear" before municipal courts and "many of these individuals have mental illness and co-occurring substance use disorders," municipal courts may be an especially effective "and often overlooked" method of diversion of individuals with mental illness from the justice system[26]; and

Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center, the National Sheriffs' Association, the Council on State Governments, and the National Center for State Courts, support the use of mental health courts[2,27-32]; and

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Whereas, While several hundred mental health courts exist across all 50 states, mental health courts do not exist in all counties and localities, indicating that these programs may not be accessible or available to all individuals who could benefit from them[4]; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA[10-12], the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including “mental health courts” (for mental illness in general), “drug courts” (for substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and sometimes certain other substance use disorders)[32-35]; and AMA policy should be inclusive of all these different types; therefore be it

Whereas, At I-19, a similar version of this resolution was adopted by our AMA-MSS as Policy 345.021MSS, establishing support for “mental health courts, including drug courts and sober courts…for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes”; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, “for individuals with addictive disease who are convicted of nonviolent crimes”; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, “for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts[36-37]; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses[36]; and

Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; and

RESOLVED, That to expand existing AMA policy on support for drug courts to the various types of mental health courts that exist and to be consistent with recently passed AMA policy on support for veteran courts, AMA Policy H-100.955, “Support for Drug Courts,” be amended by insertion and deletion as follows:

> **Support for Mental Health ~~Drug~~ Courts, H-100.955**
> Our AMA: (1) supports the establishment and use of mental health~~drug~~ courts, including drug courts and sobriety courts, as an

effective method of intervention for individuals with mental illness involved in the justice system~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
(Res. 201, A-12; Appended: BOT Rep. 09, I-19)

Support for Veterans Courts H-510.979

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Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
(Res. 202, I-19)

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
(Res. 116, A-12; Reaffirmation A-15)

Support for Justice Reinvestment Initiatives, H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Res. 205, A-16

Prevention of Impaired Driving H-30.936 (excerpted)
Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;
(CCB/CLRPD Rep. 3, A-14)

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Principles of Medical Ethics: I,III (Code of Medical Ethics Opinion, Issued: 2016)

Decisions for Adult Patients Who Lack Capacity, E-2.1.2
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
  (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
  (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
  (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
  (ii) the patient's views about life and how it should be lived;
  (iii) how the patient constructed his or her life story; and
  (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:

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(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.

(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics: I,III,VIII (Code of Medical Ethics Opinion, Issued: 2016)

Support for Mental Health Courts, 345.021MSS
AMA-MSS supports the establishment and use of mental health courts, including drug courts and sober courts, as an effective method of intervention for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes at the state and local level in the United States.
(MSS Res. 29, I-19)

Support for Veterans Courts, 345.019MSS
AMA-MSS will ask the AMA to support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
(MSS Res 24, A-19) (AMA Res. 202, Adopt as Amended [H-510.979], I-19)

Support for Drug Courts, 95.004MSS
AMA-MSS will ask the AMA to (1) support the establishment of drug courts as an alternative to incarceration and as a more effective means of overcoming drug addiction for drug-abusing individuals convicted of nonviolent crimes; and (2) encourage legislators to establish drug courts at the state and local level in the United States.
(MSS Res 29, I11) (AMA Res 201, A-12 Adopted as Amended [H-100.955]) (Reaffirmed: MSS GC Report A, I16)

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 020
(November 2020)

Introduced by: Abigail Wen-Yu Cheng, Western Michigan University Homer Stryker M.D. School of Medicine; Abigail Marie Rentschler, Michigan State University College of Human Medicine; Christopher Keane Wong, Baylor College of Medicine; Amier Haidar, McGovern Medical School; Calvin Schaffer, University of Massachusetts Medical School; Amaryllis Fernandes, McGovern Medical School
Sponsored by: Region 3, Region 4, Region 5, Region 6

Subject: Expanding Medicaid Transportation to Include Healthy Grocery Destinations
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Food insecurity is defined as the disruption of food intake or eating patterns due to lack of money and other resources[1–5]; and

Whereas, Whereas, Food insecurity increases the risk of developing chronic diseases such as obesity, type II diabetes, and cardiovascular disease[1–7]; and

Whereas, Health care expenditures from 2011-2013 of food-insecure individuals were $1,863 higher per person compared to food-secure individuals, resulting in $77.5 billion of additional health care spending[8]; and

Whereas, Medicaid eligibility is correlated with food insecurity and lack of access to grocery stores[9]; and

Whereas, In 2015, 12.7% of the United States census tracts were categorized as low income and were concurrently categorized as areas with limited access to a food store (supermarket, grocery store)[10]; and

Whereas, In 2015, 18.2 million housing units were estimated to be in low-income census tracts where at least 100 households without a vehicle lived more than half a mile from the nearest supermarket or large grocery store, or where at least a third of the tract was more than 20 miles from the nearest store[10]; and

Whereas, Over 9.5 million parents, 15.6 million nonparents, and 25.8 million children were eligible for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits in 2015[11]; and

Whereas, Individuals of lower socioeconomic status report inadequate geographical location of food stores as a major barrier to proper nutrition, including inadequate transportation[12–15]; and

Whereas, Lack of access to supermarkets, as compared to relatively ready access to convenience stores, can limit the availability of healthy foods, resulting in poorer health outcomes, such as obesity or diabetes[16–20]; and

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Whereas, There is extensive research to support that initiatives improving food access in low income populations results in improved health outcomes[21–23]; and

Whereas, Non-emergency medical transportation services (NEMT) covered by State Medicaid includes transportation for prescriptions and medical supplies but not grocery stores, farmers markets, food banks or pantries[24,25]; and

Whereas, in the past 2 decades, various pilot programs in areas such as Los Angeles, California, north Nampa, Idaho and Flint, Michigan were initiated to provide transportation to and from specific grocery stores for residents in food deserts[23,26–29]; and

Whereas, A 10-week pilot program in Michigan's Upper Peninsula to improve food access, involving a local farmer's market and 32 patients with at least one chronic disease, motivation to begin a healthy lifestyle, and demonstrated difficulty in accessing fruits and vegetables, resulted in an increase of 1.2 cups of fruits and vegetables consumed per day and a significant increase in reported quality of life[22]; and

Whereas, Participants in an East Texas transportation voucher program that included grocery store access reported improved health and well-being, and were more likely to be aware of and utilize SNAP benefits[30]; and

Whereas, Pilot test healthy food access programs found that when barriers such as cost and access were removed, individuals from lower SES communities increased their purchase and consumption of fruits and vegetables[31,32]; and

Whereas, One study found that after a full service supermarket was opened in a low SES neighborhood, the rate of increase of diagnosed high cholesterol and arthritis incidence was reduced[33]; and

Whereas, many pilot programs, such as LyftUp Grocery Access Program, run for a limited period of time, with ambiguity of future continuity, therefore offering only temporary aid[34,35]; and

Whereas, Medicaid has offered NEMT services since 1966 under the Code of Federal Regulations and authorized under the Social Security Act, providing 104 million healthcare-related trips at no cost to eligible individuals in 2013[24,36]; and

Whereas, NEMT costs Medicaid less than one percent of its total expenditures annually[37,38]; and

Whereas, current AMA policy (D-150.978) encourages the "development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation"; and

Whereas, current AMA policy (H-130.954) only encourages the "development of non-emergency patient transportation systems… [for the accessibility] of health care", there is no policy that addresses the lack of transportation support to and from healthy grocery destinations; therefore be it

RESOLVED, That our AMA (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid

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transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Non-Emergency Patient Transportation Systems H-130.954
The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. Res 812, I-93; Reaffirmed: CMS Rep 10, A-03; Reaffirmed in lieu of Res 101, A-12; Modified: CMS Rep 02, I-18

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts. Res 921, I-18

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the

Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. Res 414, A-10; Reaffirmed A-12; Reaffirmation A-13; Appended: CSAPH Rep 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res 407, A-17; Appended: Res 233, A-18

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

Medicare’s Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient’s needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations. Res 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep 3, A-08; Modified: Res 124, A-17

Programs to Combat Food Deserts 150.026MSS
AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows: D-150.978 Sustainable Food “Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. MSS Res 19, I-12; AMA Res 204, A-13, Adopted [D-150.978]; Reaffirmed: MSS GC Report A, I-17

Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs 150.029MSS

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AMA-MSS will ask the AMA to support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors. MSS Res 12, I-14; Existing Policy Reaffirmed in Lieu of AMA Res 405, A-15; Reaffirmed: MSS GC Rep A, I-19

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

Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S. 150.040MSS
AMA-MSS supports evidence-based methods of addressing food insecurity. MSS CGPH Report A, A-19

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 021
(November 2020)

Introduced by: Michael McNamara, Medical College of Wisconsin; Drayton Harvey, Keck School of Medicine of USC; Zachary Dunton, University of Wisconsin School of Medicine and Public Health; Alexander Lupi, Vanderbilt University School of Medicine; Kavya Magham, WSU Elson S. Floyd College of Medicine; Megan Quamme, Medical College of Wisconsin; Fraya King, LSU School of Medicine in New Orleans; Neha Siddiqui, Carle Illinois College of Medicine

Sponsored by: Region 2, Region 3, Region 6

Subject: Reconsideration of the Dead Donor Rule to Exempt Maastricht Class III Donors

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The U.S. Organ Procurement and Transplantation Network reports that as of January 2020, there were 3,682 people on the waiting list for heart transplants in the United States, and in all of 2019 there were more new additions to the waiting list than there were heart transplants[1]; and

Whereas, Between 2011 and 2014, the average wait time for a highest-priority patient on the heart transplant waiting list was 87 days, and only 70% of people who were on the list for 2 years received a heart transplant[1]; and

Whereas, The Dead Donor Rule (DDR) maintains that 1) organ donors must be dead before procurement of organs begins and 2) organ procurement itself must not cause the death of the donor[2,3]; and

Whereas, The DDR is an ethical norm, not codified in law, and the only legal foundation for the DDR is the Uniform Determination of Death Act adopted in some form in 47 states which defines brain death, thus codifying when an individual qualifies to be a donor[2,3]; and

Whereas, The Uniform Determination of Death Act defines total brain death as irreversible cessation of all functions of the entire brain, including the brain stem, as a valid criterion for death which requires extensive technical qualifications[2,3]; and

Whereas, There are two classes of organ donors:

1. Donors after brain death (DBD), considered heart-beating donors
2. Donors after cardiac death (DCD), considered non-heart beating donors[4]; and

Whereas, Unlike DBDs, DCD non-heart beating donors are classified using the Maastricht classification which is solely a set of agreed upon definitions that provides the transplant community with consistent definitions for types of DCD[5]; and

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Whereas, The Maastricht classification of DCD non-heart beating donations identifies the five categories of DCD donors as[5]:

I. Dead on arrival at hospital (Uncontrolled)
II. Death with unsuccessful resuscitation (Uncontrolled)
III. Awaiting cardiac death (Controlled)
IV. Cardiac arrest while brain dead (Uncontrolled)
V. Circulatory arrest in hospital (Uncontrolled); and

Whereas, A non heart-beating donor in Maastricht Category III (awaiting cardiac death) does not meet the technical definition of brain death, but is on an intensive care unit with a non-survivable condition, for whom there is no possibility of recovery, and will die when artificial life support is withdrawn[5]; and

Whereas, Non heart-beating donors in Maastricht Category III (awaiting cardiac death) are uniquely considered 'controlled' donors because cardiac life is sustained, often for an extended period, solely for the purpose of evaluation and planning for transplantation of all viable organs[5]; and

Whereas, For non heart-beating donors, 2-5 minutes of cardiac arrest must occur prior to removal of all organs for transplant to comply with the Dead Donor Rule[6]; and

Whereas, Since Maastricht Category III (awaiting cardiac death) donors must have cardiac arrest for 2-5 minutes to be considered eligible to donate, their hearts are not widely donated, as they are considered no longer viable for transplant[6]; and

Whereas, The technology to maintain perfusion of hearts after cardiac arrest for DCD is still being studied in small cohorts of only 180 in the US and 45 in Europe[7–10]; and

Whereas, It has been shown that patients receiving grafts from DCD donors have diminished long-term survival compared to DBD donors, thus better outcomes may result from donation prior to cardiac arrest in Maastricht Class III donors[11]; and

Whereas, A survey of European countries showed that over 19,000 DCD transplants were performed between 2008 and 2016 demonstrating the extensive potential for expanding the donor pool[8]; and

Whereas, Bioethicists have argued that the Dead Donor Rule infringes on donor autonomy by preventing organ donation from donors and families who wish to donate organs[6,12]; and

Whereas, Medical ethicists argue that the Dead Donor Rule undermines the trust donors have in organ procurement procedures when the medical community fails to follow the request of the donor to utilize all viable organs, including the heart[13]; and

Whereas, Medical ethicists have proposed that, when the patient or their surrogate decision-maker has decided that the burdens of treatment outweigh its benefits, the act of withdrawing life-sustaining therapy in DCD is ethically acceptable[14]; and

Whereas, Withdrawal of life-sustaining treatment is permitted in DCD programs only if it has been decided independently of organ donation[14]; and

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Whereas, There has been evidence showing that neither the physician managing end of life care nor the independent organ donation team accelerates the demise of patients who ultimately choose to donate organs[15]; and

Whereas, A landmark public survey study displayed significant support (76% of 1096 surveyed) for organ donation in a scenario explicitly described as violating the Dead Donor Rule[16]; and

Whereas, In an interview study of families (n=15) who had direct experience with DCD, participants reported experiencing a spectrum of harms including, "waste of precious life-giving organs and hospital resources, inability to honor the donor's memory and character, and impaired ability for families to make sense of tragedy and cope with loss,"[17]; and

Whereas, The American Society of Transplant Surgeons has recommendations for transplant of every organ except for heart transplantation in the case of donation after cardiac death[4]; and

Whereas, Multiple AMA policies, especially Organ Donation D-370.985, call for increasing the pool of organ donors in an ethical manner and demonstrate a dedication to pursuing new ways of thinking to approach organ donation; and therefore be it

RESOLVED, That our AMA supports reconsideration of the Dead Donor Rule specifically in the case of cardiac transplantation for Maastricht Category III donors who would otherwise be precluded from heart donation in order to expand the donor pool in an ethical manner.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

6.2.1 Guidelines for Organ Transplantation from Deceased Donors: Transplantation

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician's primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and

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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 recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.

(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.

(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.

(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

Issued: 2016

6.1.2 Organ Donation After Cardiac Death

Increasing the supply of organs available for transplant serves the interests of patients and the public and is in keeping with physicians' ethical obligation to contribute to the health of the public and to support access to medical care. Physicians should support innovative approaches to increasing the supply of organs for transplantation, but must balance this obligation with their duty to protect the interests of their individual patients.

Organ donation after cardiac death is one approach being undertaken to make greater numbers of transplantable organs available. In what is known as "controlled" donationafter cardiac death, a patient who has decided to forgo life-sustaining treatment (or the patient's authorized surrogate when the patient lacks decision-making capacity) may be offered the opportunity to discontinue life support under conditions that would permit the patient to

become an organ donor by allowing organs to be removed promptly afterdeath is pronounced. Organ retrieval under this protocol thus differs from usual procedures for cadaveric donation when the patient has died as a result of catastrophic illness or injury.

Donation after cardiac death raises a number of special ethical concerns, including how and when death is declared, potential conflicts of interest for physicians in managing the withdrawal of life support for a patient whose organs are to be retrieved for transplantation, and the use of a surrogate decision maker.

In light of these concerns, physicians who participate in retrieving organs under a protocol of donation after cardiac death should observe the following safeguards:

(a) Promote the development of and adhere to clinical criteria for identifying prospective donors whose organs are reasonably likely to be suitable for transplantation.

(b) Promote the development of and adhere to clear and specific institutional policies governing donation after cardiac death.

(c) Avoid actual or perceived conflicts of interest by:

(i) ensuring that the health care professionals who provide care at the end of life are distinct from those who will participate in retrieving organs for transplant;

(ii) ensuring that no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.

(d) Ensure that the decision to withdraw life-sustaining treatment is made prior to and independent of any offer of opportunity to donate organs (unless organ donation is spontaneously broached by the patient or surrogate).

(e) Obtain informed consent for organ donation from the patient (or surrogate), including consent specifically to the use of interventions intended not to benefit the patient but to preserve organs in order to improve the opportunity for successful transplantation.

(f) Ensure that relevant standards for good clinical practice and palliative care are followed when implementing the decision to withdraw a life-sustaining intervention.

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

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Ethical Issues in the Procurement of Organs Following Cardiac Death H-370.975

The Pittsburgh Protocol: The following guidelines have been adopted:
The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended:
(a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation.
(b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that they may decide with their physicians whether to accept the organs or wait for more suitable ones.
(c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol.
CEJA Rep. 4 - I-94Reaffirmed: CSA Rep. 4, I-02Reaffirmed: CEJA Rep. 3, A-12

Increasing Organ Donation H-370.971

Our AMA recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care.
CSA Rep. 4, I-02Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.995

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following:

(1) the need for organ donors;
(2) the success rate for organ transplantation;
(3) the medico-legal aspects of organ transplantation;
(4) the integration of organ recruitment, preservation and transplantation;
(5) cost/reimbursement mechanisms for organ transplantation; and

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(6) the ethical considerations of organ donor recruitment.
Res. 32, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 6, A-00Reaffirmed: CSA Rep. 4, I-02Reaffirmed: CSAPH Rep. 1, A-12

Organ Donation D-370.985

Our AMA will study potential models for increasing the United States organ donor pool.
Res. 1, A-14Reaffirmed in lieu of Res. 5, I-14Reaffirmed in lieu of: Res. 002, I-16

Ethical Procurement of Organs for Transplantation H-370.967

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
BOT Rep. 13, A-08Reaffirmed: CEJA Rep. 06, A-18

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that

physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

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

Ethical Issues in the Procurement of Organs Following Cardiac Death H-370.975

The Pittsburgh Protocol: The following guidelines have been adopted:
The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended:
(a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation.
(b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that

they may decide with their physicians whether to accept the organs or wait for more suitable ones.
(c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol.
CEJA Rep. 4 - I-94Reaffirmed: CSA Rep. 4, I-02Reaffirmed: CEJA Rep. 3, A-12

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 022
(November 2020)

Introduced by: Abby Dillaha, Glen McClain, Thomas Troy, University of Cincinnati College of Medicine; Ian Maynor, University of California, San Francisco School of Medicine; Brandon Francis, Indiana University School of Medicine

Sponsored by: Region 1, Region 4, Region 5, Region 6, Region 7

Subject: Ensuring Consent during Educational Physical Exams on Unconscious Patients

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the patient's right to accept, modify, and refuse treatment[1,2]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed consent as "a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care" and a patient may only provide informed consent after being informed of their diagnosis if known, the nature and purpose of any recommended interventions, and the anticipated risks, benefits, and consequences of all options[3-6]; and

Whereas, Providers are legally and ethically obligated to inform patients as part of the consent process who may be involved in their care[4,7]; and

Whereas, Teaching hospitals historically used the generalized consent form as permission to perform exams in private areas without explicitly providing patients opportunity to indicate limits on involvement from specific teams or any of their members[5,8-12]; and

Whereas, A 2003 survey found 90% of medical students in Philadelphia performed pelvic exams on anesthetized patients and a 2005 survey at an Oklahoma medical school confirmed that this practice was common and that nearly 75% of those exams were conducted without explicit prior consent[13,14]; and

Whereas, Many of these non-consented pelvic exams were performed solely for educational purposes, oftentimes by medical students not involved in the patient's care and when the patient's surgical indications did not involve the anatomic areas being examined[15]; and

Whereas, Some instructors' belief that it is important for medical students to perform invasive exams for educational purposes while patients are anesthetized, in addition to pressures to achieve high academic and clinical marks, may contribute to medical students agreeing to perform these exams without considering that additional patient consent should be obtained[13,16-21]; and

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Whereas, The AMA Code of Ethics states patient "participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance."[22]; and

Whereas, While patients historically have been open to student involvement in their care, they believe that invasive exams of genitalia warrant specific consent beyond the level provided for general care[23-25]; and

Whereas, The Association of Professors of Gynecology and Obstetrics (APGO) and ACOG have both emphasized that pelvic exams performed under anesthesia for educational purposes should only be done with a patient's informed consent prior to conducting the exam[21,26]; and

Whereas, The states of Illinois, Oregon, California, Hawaii, Virginia, Iowa, Maryland, Utah, New York, and Delaware have outlawed pelvic examination on a woman who is anesthetized or unconscious for purely educational purposes without prior consent[27-36]; and

Whereas, Some medical schools in states where this practice remains legal have developed their own policies to ensure protections for patients and students in situations where sensitive exams may be performed under anesthesia for educational purposes[37,38]; therefore be it

RESOLVED, That our AMA-MSS oppose performing physical exams on patients under anesthesia or on unconscious patients when these exams are not urgently medically necessary or without prior informed consent to do so; and be it further

RESOLVED, That our AMA-MSS encourage institutions to adopt policies that ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia.

Fiscal Note: TBD

Date Received: XX/XX/XXXX

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RELEVANT AMA AND AMA-MSS POLICY

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient

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lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. Issued: 2016

7.1.2 Informed Consent in Research
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:
(a) Ascertaining that the individual has decision-making capacity.
(b) Reviewing the process and any materials to ensure that it is understandable to the study population.
(c) Disclosing:
(i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
(ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
(iv) the likelihood of therapeutic or other direct benefit for the participant;
(v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
(vi) the nature of the research plan and implications for the participant;
(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
(d) Answering questions the prospective participant has.
(e) Refraining from persuading the individual to enroll.
(f) Avoiding encouraging unrealistic expectations.
(g) Documenting the individual's voluntary consent to participate.
Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:

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(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.
(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
(j) There is potential for the individual to benefit from the study.
In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions. Issued: 2016

2.1.6 Substitution of Surgeon
Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the surgeon has an ethical responsibility to:

(a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.
(b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines. Issued: 2016

2.3.6 Surgical Co-Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.
Issued: 2016

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students

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Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as “patients” are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students’ privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:
(a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
(b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
(c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.
(d) Allow students the choice of whether to participate prior to entering the classroom.
(e) Never require that students provide a reason for their unwillingness to participate.
(f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students’ overall performance based on their willingness to volunteer as “patients.” Issued: 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure. Res 226, A-99; Reaffirmed: Res 703, A-00; Reaffirmed: BOT Rep. 6, A-10

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.
(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

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(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

Teacher-Learner Relationship in Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the **teacher** and the **learner**; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The **teacher**-**learner** relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of **teacher**.

In the **teacher**-**learner** relationship, each party has certain legitimate expectations of the other. For example, the **learner** can expect that the **teacher** will provide instruction, guidance, inspiration, and leadership in learning. The **teacher** expects the **learner** to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the **teacher**-**learner** relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

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On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among **teacher** and **learner** to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13

140.002 MSS Bioethical Determinations
It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions regarding his or her own health care and the determination of who makes decisions for health care in the non-competent patient. MSS Rep C, I-82 Attachment 4; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 023
(November 2020)

Introduced by: Anna Heffron, University of Wisconsin School of Medicine and Public Health; Dayna Isaacs, University of California, Davis School of Medicine; Akshara Malla, John Raynak, University of Arizona College of Medicine, Phoenix; Rohan Khazanchi, University of Nebraska Medical Center College of Medicine; Raj Reddy, Baylor College of Medicine; Christopher Blanco, Indiana University School of Medicine – Evansville; Rachana Raghupathy, Northeast Ohio Medical University

Sponsored by: Region 2, Region 3, Region 4, Region 5

Subject: Decreasing Youth Access to E-cigarettes

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Centers for Disease Control and Prevention (CDC) defines an “e-cigarette” (also known as “e-cig,” “e-hookah,” “mod,” “vape pen,” “vape,” “tank system,” and “electronic nicotine delivery system”) as a device that produces an aerosol by heating a liquid that usually contains nicotine, flavorings, and other chemicals, such as diacetyl, volatile organic compounds, and heavy metals, that help to make the aerosol[1]; and

Whereas, Per the CDC, the act of using this device is termed as “vaping,” which allows for ultrafine particles to be inhaled deeply into the lungs[1]; and

Whereas, Youth use of electronic cigarettes is widespread in the US, with 10.5% of middle school students and 27.5% of high school students reporting in 2019 that they used electronic cigarettes in the past 30 days[2-5]; and

Whereas, From July 2019 through February 2020, electronic cigarette, or vaping, product use-associated lung injury (EVALI) resulted in the hospitalization of 2,807 people across the United States and at least 68 deaths, with a majority of affected patients being under 25 years of age[6]; and

Whereas, A single cartridge of the e-cigarettes used by the majority of US youth has a nicotine content equivalent to roughly 20 combustible cigarettes, and nicotine has been determined to be a highly addictive substance that can adversely harm the developing adolescent brain[4,7]; and

Whereas, The safety and health effects of long-term inhalation of the volatile organic compounds, heavy metals, and known cancer-causing agents contained in e-cigarettes are currently unknown[8]; and

Whereas, The Food and Drug Administration (FDA)’s restrictions on flavored e-cigarettes passed in February 2020 narrowly targeted pre-filled cartridge-based vaping devices and do not apply to disposable or refillable tank-based products based on the FDA’s “interest in balancing

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between preventing youth usage and preserving options for adults trying to transition away from combustible products"[9,10]; and

Whereas, Existing AMA-MSS policy 490.025MSS "acknowledges the known harms of electronic nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices" and existing AMA policy D-495.992 acknowledges the insufficiency of data on the safety and effectiveness of e-cigarettes products for tobacco cessation purposes; and

Whereas, Recent news reports suggest an immediate increase in youth use of flavored disposable e-cigarettes in response the FDA's restrictions on cartridge-based e-cigarettes[11,12]; and

Whereas, Prior to the recent popularity of cartridge-based devices, refillable tank-based devices were the most popular e-cigarette type among youth, with 51.8% of youth using tank-based e-cigarettes as compared to 47.1% using cartridge-based e-cigarettes in 2017[10,13]; and

Whereas, Disposable e-cigarettes and tank-based devices contain the same ingredients as cartridge-based devices and are considered by the CDC to be in the same overarching category as cartridge-based devices[1]; and

Whereas, Despite use of e-liquids with the same nicotine concentration, modifiable tank-based e-cigarette products are thought to deliver higher levels of nicotine as compared to other e-cigarette products[14]; and

Whereas, High tobacco retailer density increases access to tobacco products and the likelihood of smoking initiation, particularly among youth because identification is requested less often, prices decrease due to increased competition, and there are more advertisements that incentivize purchase in high-density tobacco retail areas[15-18]; and

Whereas, Experimental smoking among high school-aged minors increases when tobacco retailers are closer to schools and densely populate those locations[19,20]; and

Whereas, Higher tobacco retailer densities proximal to schools and homes are disproportionately prevalent in low-income communities and communities of color, posing a significant public health injustice, and policies banning tobacco product sales near schools have been projected to reduce or eliminate existing disparities in tobacco retailer density by income level and by proportion of African American residents[17,21,22]; and

Whereas, Proximity-based point of sale laws that restrict sale of tobacco or opening of new tobacco retailers within a certain distance of schools, playgrounds, parks, libraries, and existing retailers have been successfully implemented in California, Illinois, Louisiana, and Rhode Island[23-28]; and

Whereas, E-cigarette marketing in the US contains features that are particularly more appealing to youth, and youth exposed to e-cigarette advertisements are significantly more likely to initiate vaping[29,30];

Whereas, E-cigarette package warning labels that communicate the health risks of e-cigarettes can reduce students' intention to use e-cigarettes and increase perceived risks of e-cigarette use[31]; and

Whereas, Adolescents who vape e-cigarettes in nontraditional flavors are more likely to continue vaping and take more puffs per vaping occasion, compared with those who exclusively vaped tobacco-flavored, mint- or menthol-flavored, or flavorless e-cigarettes[32]; and

Whereas, Although a number of policies (H-490.914, H-495.971, H-495.972, H-495.973, H-495.984, and H-495.989, among others) regarding vaping and e-cigarettes have been adopted by the AMA, the AMA-MSS has scarce internal policy to guide our actions on these topics; therefore be it

RESOLVED, That our AMA support the inclusion of disposable and tank-based e-cigarettes in the language and implementation of any restrictions that are applied by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes; and be it further

RESOLVED, That AMA policy H-495.986 be amended by insertion as follows:

Tobacco Product Sales and Distribution, H-495.986

Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;

(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and

(9) opposes the sale of tobacco at any facility where health services are provided; and

(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

<u>(11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and</u>

<u>(12) support measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in proximity to existing tobacco specialty stores</u>

; and be it further

RESOLVED, That our AMA-MSS establish formal support for AMA policies H-490.914, H-495.971, H-495.972, H-495.973, H-495.984, and H-495.989.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Tobacco Prevention and Youth H-490.914
Our AMA:
(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;
(2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;
(3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;
(4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.

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(5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;
(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;
(7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;
(8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and
(9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).
CSA Rep. 3, A-04; Modified: Res. 402, A-13

FDA Regulation of Tobacco Products H-495.988
1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

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2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.
3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy.
CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19

Opposition to Addition of Flavors to Tobacco Products H-495.971
Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco.
CSAPH Rep. 01, A-18; Modified: Res. 916, I-18; Modified: Res. 918, I-19

Electronic Cigarettes, Vaping, and Health H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.
CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19

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FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA:

(1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act;

(2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and

(3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18; Reaffirmation: I-19

Tobacco Advertising and Media H-495.984

Our AMA:

(1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;

(2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;

(3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;

(4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;

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(5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising;
(6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;
(7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;
(8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;
(9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;
(10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;
(11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;
(12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;
(13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and
(14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.
CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986
Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to

counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18; Reaffirmation: I-19

Tobacco Product Labeling H-495.989
Our AMA:
(1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States);
(2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking;
(3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content

in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;"
(4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and
(5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.
CSA Rep. 3, A-04; Modified: Res. 402, A-13; Modified: Res. 925, I-16; Modified: Res. 428, A-19

Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992
1. Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.
2. Our AMA will: (a) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only; and (b) will advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes.
Res. 432, A-18; Appended: Res. 910, I-19

Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes 490.025MSS
AMA-MSS will (1) acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices, and encourage physicians to recommend alternative therapies for smoking cessation; (2) work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices; and (3) support increasing the age of purchase for all tobacco products from age 18 to 21. (MSS Res 28, A-18)

Restricting the Sale of E-Cigarettes to Minors 500.006MSS
AMA-MSS supports (1) increased clinical research on the effects of electronic cigarettes; and (2) education on the effects of e-cigarettes to parents and their children in various settings ranging from schools to clinics. (MSS Res 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 024
(November 2020)

Introduced by: Alyssa Greenwood Francis, Allen Wang, Rachel Kitch, Luis Salcido, Abhishek Dharan, Texas Tech University Health Science Center El Paso; Tristan Mackey, University of South Carolina School of Medicine Greenville; Klarissa Saldivar, Zavher Momin, University of Texas Medical Branch at Galveston; Cameron Holguin, University of Texas Health San Antonio Long School of Medicine

Sponsored by: Region 4

Subject: Amending Policy D-350.983 to Include Board-Certification and Community Physician Oversight

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, There are 135 U.S. Immigration and Customs Enforcement (ICE) and 132 U.S. Customs and Border Protection (CBP) immigrant detention facilities in the United States[1,2]; and

Whereas, Human beings are being held for increasingly longer periods of time in these immigrant detention facilities, with the average length of stay increasing from 22 days in 2016 to 34 days in 2017, and recent delays in immigration processing from the COVID-19 pandemic are prolonging people's stay in detention facilities[3,4]; and

Whereas, Detention facilities are unsanitary and overcrowded, lacking basic supplies such as clean water, clean clothes, and facilities for bathing and handwashing[5]; and

Whereas, In 2019, the Department of Homeland Security Office of the Inspector General reported that ICE has a documented history of refusing to adequately report data on the daily operations of its facilities, even though lapses in compliance with detention standards are known to occur, such as understaffing and failure to provide mental health services[6]; and

Whereas, ICE repeatedly avoids paying penalties for noncompliance with federal safety standards, even when those noncompliances pose serious safety and health risks to detainees[6]; and

Whereas, Inadequate access to medical care within immigrant detention facilities has been well documented and found to be a contributing factor in 23 out of 52 deaths in ICE detention facilities between March 2010 to March 2018[7]; and

Whereas, The American Academy of Pediatrics supports immediate access to medical care when a child enters a Detention Facility and, further, does not believe children should be held in immigration detention for any period due to the inability to provide appropriate health care[8]; and

Whereas, Detention facilities lack a centralized authority overseeing the provision of medical care, since the ICE Health Service Corps (IHSC) only manages the healthcare of 22 out of 200

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immigration detention facilities, leading to inconsistencies in the provision of medical care, with multiple contracts lacking specific staffing requirements or 24-hour access to care[9,10]; and

Whereas, Scope of practice violations, including having licensed vocational nurses clinically assess patients without physician oversight, and medical neglect, including refusing care to individuals with shortness of breath, are documented occurrences inside detention facilities[11,12]; and

Whereas, Severe medical neglect recently occurred in an ICE detention facility in Georgia where a physician, practicing as a non-board-certified gynecologist, performed unnecessary hysterectomies on at least 17 women[12,13]; and

Whereas, Only one-third of ICE detention centers are located within 25 miles of a hospital with intensive care beds, further emphasizing the need for adequate access to care within facilities to prevent worsening conditions[14]; and

Whereas, Community physicians, otherwise known as non-contracted medical personnel, were allowed by the United States Customs and Border Protection to provide medical care within Immigrant Detention Facilities in 2014, but starting in 2018 physicians have been denied access to those same facilities to provide medical care[15]; and

Whereas, When community physicians were allowed to provide care in CBP detention facilities in 2014, 20 community physicians were on call every day to evaluate children and adults, improving the provider-to-patient ratio in these detention centers[15]; and

Whereas, United States District Judge Dolly Gee, supported by 80 physicians and lawyers, ordered the Attorney General of the United States in June 2019 to allow physicians access to the Customs and Border Protection Detention Facilities in the El Paso and Rio Grande Valley Regions, in response to findings that children were not receiving medical care due to community physicians being denied access to these facilities[16]; and

Whereas, The United States House of Representatives H.R. 3239, the “Humanitarian Standards for Individuals in Customs and Border Protection Custody Act,” bill passed on July 2019 outlines sanitation improvements for detention facilities, but does not address improvements for medical care provision within detention facilities[17]; and

Whereas, The American Medical Association has policy supporting improved medical care in immigrant detention facilities, including supporting adherence to the medical standards set by the National Commission on Correctional Health Care, but these policies lack support for physicians maintaining board-certification in their respective specialty and lack support for allowing community medical professionals to provide oversight inside these facilities to improve the standardization and provision of medical care[18-21]; therefore be it

RESOLVED, That our AMA amend policy D-350.983, Improving Medical Care in Immigrant Detention Centers, to support community physicians accessing U.S. Immigrations and Customs

Enforcement and Customs and Border Patrol facilities to provide medical care to individuals detained in these buildings by addition and deletion as follows:

Improving Medical Care in Immigrant Detention Centers, D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; ~~and~~ (3) support requiring physicians providing care within detention facilities to maintain board-certification in the specialty they are practicing and allowing community physicians oversight in U.S. Immigration Enforcement and Customs and Border Protection facilities; and (~~3~~4) advocate for access to health care for individuals in immigration detention.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. (Res. 017, A-17)

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

Our AMA (1) will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue; (2) urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation; (3) will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation; (4) will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition. (Res. 5, I-15Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18)

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968

Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services

that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02Reaffirmation A-07Reaffirmed: CMS Rep. 01, A-17Reaffirmation: A-19Reaffirmation: I-19)

Qualifications of Health Professionals H-275.975
(1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals. (BOT Rep. NN, A-87Reaffirmed: Sunset Report, I-97Reaffirmed: CME Rep. 2, A-07Reaffirmed: CME Rep. 01, A-17)

Medical Specialty Board Certification Standards H-275.926

Our AMA: (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Res. 318, A-07Reaffirmation A-11Modified: CME Rep. 2, I-15Modified: Res. 215, I-19)

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Physician and Nonphysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
(CME Rep. 1, I-00Reaffirmed: CME Rep. 2, A-10Modified: CCB/CLRPD Rep. 2, A-14Appended: Res. 251, A-18Appended: Res. 222, I-19)

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

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and well- being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

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

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presence of U.S. Immigrations and Customs Enforcement (ICE) at healthcare facilities. (MSS Res 43, I-17) (AMA Res 232, I-17, Adopted [D-160.921])

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal) (AMA Res 018, A-17 Adopted [H-315.96])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 025
(November 2020)

Introduced by: Katrina Marks, Natasha McGlaun, Sam Genis, Ben Wagner, University of Nevada, Reno School of Medicine; Cindy Tsui, Eric Hirsch, SUNY Downstate College of Medicine; Skylar Rains, University of California, Riverside School of Medicine; Monica Celine Fortich, University of Nevada, Las Vegas School of Medicine; Nikita Sood, Washington University in St Louis School of Medicine; Julia Seiberling, University of California Riverside School of Medicine'; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Sanjay Das, Central Michigan University College of Medicine

Sponsored by: Region 6

Subject: Banning the Practice of Virginity Testing

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, A "virginity exam" or "virginity test" is defined as an exam to assess the hymen for tears and inspect the vaginal walls and introitus for laxity for the purpose of determining whether a female has ever had sexual intercourse[1]; and

Whereas, "Virginity testing" differs from female genital mutilation in that female genital mutilation involves either partial or full removal of or otherwise injuring external female genitalia and "virginity exams" do not[15]; and

Whereas, "Virginity testing" is a complex, culturally mediated practice which may be seen in some patient populations and may be poorly understood by U.S. clinicians[2]; and

Whereas, A survey conducted by The American College of Obstetricians and Gynecologists showed that 10% of obstetrician/gynecologists in the United States have been asked to perform "virginity testing," and 34.5% of these physicians fulfilled these requests[2,17]; and

Whereas, U.S. physicians who perform requested "virginity tests" report not knowing why they are performing the test, and almost none of them ask the patient or family why the test is being requested[2, 13, 14]; and

Whereas, Little guidance has been published for clinicians who encounter requests for "virginity testing" in the clinical settings, and physicians who are asked to perform "virginity testing" report feeling they are not properly equipped to respond to these requests[2, 13, 14]; and

Whereas, "Virginity testing" is an extremely invasive procedure that is often performed under coercion from a third party, such as family or spouses, and/or without patient consent, and by itself confers no physical, mental, or emotional health benefit to the patient undergoing the exam[1,2, 7]; and

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Whereas, “Virginity exams” may be physically harmful to the examinee as these exams may lead to hymenal damage, bleeding, or infection[3]; and

Whereas, Many anatomic variants of the hymen exist, including congenital abnormalities, natural changes in a woman’s lifespan, and injury resulting from non-sexual activities, and sexual intercourse or assault may not result in identifiable changes to hymenal tissue, thus “virginity exams” cannot reliably predict virginity status[1,3,4,5,6,7]; and

Whereas, The Independent Forensic Expert Group has stated that “virginity testing” is inherently discriminatory because it correlates intercourse with immorality or criminal deviance and can only be performed on female-typical anatomy[3]; and

Whereas, “Virginity exams” have been shown to have negative psychological consequences on the examinee including but not limited to lower self-confidence, depression, and suicidal ideation, as well as lifelong effects such as post-traumatic stress disorder and anxiety[1,2,3]; and

Whereas, There have been reported instances of “virginity exam” results leading to patient self-harm, murder, and physical violence against examinees[1,3]; and

Whereas, In 2018, the World Health Organization and the United Nations publicly called for an end to the practice of “virginity testing,” as it is a violation of human rights on the basis of gender discrimination, inhumane treatment and punishment, and violation of privacy[2,8]; and

Whereas, The American College of Obstetricians and Gynecologists supports efforts to eliminate the practice of “virginity testing” on the grounds of its medical invalidity and adverse effects to the examinee[12]; and

Whereas, BMJ Global Health recommends educating and counseling patients about the lack of reliability and the possible harms of “virginity testing” through training community members, reading materials, and inclusion in other reproductive health discussion[2]; and

Whereas, The California Assembly (AB 1909) and the New York State Assembly (A08742) and Senate (S06879) have already introduced bills to prevent doctors from performing or supervising a “virginity examination”[9,10,11]; and

Whereas, Our AMA has policies that promote trauma-informed care that avoids re-traumatizing patients and recognizes the effect of trauma on patients (H-515.952); and

Whereas, The AMA Code of Ethics (5.5 and 8.5) recognizes that “Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded” as well as that gender disparities in health care can stem from arbitrary evaluations that are not directly related to a patient’s clinical needs; therefore be it

RESOLVED, That our AMA: (1) advocates for banning the practice of virginity testing exams;

(2) supports culturally-sensitive counseling by providers to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support;

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(3) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued existence of the practice of virginity testing in the United States and abroad and its detrimental effects on patients.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

H-525.980 Expansion of AMA Policy of Female Genital Mutilation

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Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.
CSA Rep. 5, I-94Res. 513, A-96Reaffirmed: CSAPH Rep. 3, A-06Modified: Res. 9, A-12Reaffirmed: BOT Rep. 15, A-17

H-60.938 Adolescent Sexual Activity

Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and
(b) supports the following principles for consideration in development of public policy:

- (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships;
- (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening;
- (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases;
- (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate;
- (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and
- (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

Res. 825, I-04Modified: CSAPH Rep. 1, A-14

H-525.987 Surgical Modification of Female Genitalia

Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia.

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Res. 13, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CEJA Rep. 8, A-11

H-515.952 Adverse Childhood Experiences and Trauma Informed Care

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.
Res. 504, A-19

5.5 Medically Ineffective Interventions

At times patients (or their surrogates) request interventions that the physician judges not to be medically appropriate. Such requests are particularly challenging when the patient is terminally ill or suffers from an acute condition with an uncertain prognosis and therapeutic options range from aggressive, potentially burdensome life-extending intervention to comfort measures only. Requests for interventions that are not medically appropriate challenge the physician to balance obligations to respect patient autonomy and not to abandon the patient with obligations to be compassionate, yet candid, and to preserve the integrity of medical judgment.

Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician's considered medical judgment about the risks and likely benefits of available options in light of the patient's goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them.

Many health care institutions have promoted policies regarding so-called "futile" care. However, physicians must remember that it is not possible to offer a single, universal definition of futility." The meaning of the term "futile" depends on the values and goals of a particular patient in specific clinical circumstances.

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As clinicians, when a patient (or surrogate on behalf of a patient who lacks decision-making capacity) request care that the physician or other members of the health care team judge not to be medically appropriate, physicians should:

(a) Discuss with the patient the individual's goals for care, including desired quality of life, and seek to clarify misunderstandings. Include the patient's surrogate in the conversation if possible, even when the patient retains decision-making capacity.

(b) Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be provided unless the patient declines particular interventions (or the surrogate does so on behalf of a patient who lacks capacity).

(c) Negotiate a mutually agreed-on plan of care consistent with the patient's goals and with sound clinical judgment.

(d) Seek assistance from an ethics committee or other appropriate institutional resource if the patient (or surrogate) continues to request care that the physician judges not to be medically appropriate, respecting the patient's right to appeal when review does not support the request.

(e) Seek to transfer care to another physician or another institution willing to provide the desired care in the rare event that disagreement cannot be resolved through available mechanisms, in keeping with ethics guidance. If transfer is not possible, the physician is under no ethical obligation to offer the intervention.

As leaders within their institutions, physicians should encourage the development of institutional policy that:

(f) Acknowledges the need to make context sensitive judgments about care for individual patients.

(g) Supports physicians in exercising their best professional judgment.

(h) Takes into account community and institutional standards for care.

(i) Uses scientifically sound measures of function or outcome.

(j) Ensures consistency and due process in the event of disagreement over whether an intervention should be provided.

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

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To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 026
(November 2020)

Introduced by: Natasha Topolski, Kareem Wahid; McGovern Medical School at the University of Texas Health Science Center at Houston; Samantha Pavlock, Florida State University College of Medicine; Krithika Sundaram, Meghana Chanamolu; Northeast Ohio Medical University.

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6

Subject: Non-Cervical HPV Associated Cancer Prevention

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, While Human Papillomavirus (HPV) infection with high risk strains is a well-known risk factor for cervical cancer and widespread efforts have been made to educate healthcare providers and the public about screening and vaccination for cervical cancer prevention, HPV infection has also been associated with the development of other cancers such as vulvar, vaginal, head and neck, penile, and anal cancer, among others[1–5]; and

Whereas, Of the approximately 34,800 new cases of HPV-related cancer diagnoses in the U.S. annually, less than one third are due to cervical cancer and 40% are found in males[6]; and

Whereas, HPV associated head and neck cancer predominates in males in a ratio of 8:1 and has increased in prevalence by 225% since the 1980s, and the annual number of cases are expected to surpass the annual number of cervical cancers per year by 2020[7]; and

Whereas, HPV vaccination has been recommended by the U.S. Food and Drug Administration (FDA) for females ages 9 to 26 for cervical, vulvar, and vaginal cancer prevention since 2006, all individuals for the prevention of anal cancer since 2010, individuals up to age 45 that may be at higher risk of infection since 2018, and for head and neck cancer prevention since 2020[10,11]; and

Whereas, Despite HPV vaccination being recommended for all individuals, vaccination rates are still suboptimal, and significantly lower for males (27.4% - 56%) compared to females (45.7% - 65%), with approximately 37% of individuals receiving all three doses[12–15]; and

Whereas, It has been hypothesized that vaccination rates are suboptimal in part due to a “feminization of HPV” that evolved from a focus on cervical cancer screening and the conception of women bearing the burden of HPV related illness, which suggests that vaccination rates may increase if stakeholders actively work to normalize HPV vaccination as an important gender-neutral component of routine healthcare[16]; and

Whereas, A 2019 meta-analysis showed that healthcare professionals’ knowledge and counseling tendencies regarding HPV infection and vaccination remain low and are crucial to vaccine uptake; notably many providers are unaware that HPV is associated with non-cervical cancers and that the HPV vaccine can prevent non-cervical cancers[17–20]; and

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Whereas, In a study of pediatric residents and fellows, 68.3% rated their prior education as “none” or “fair” regarding HPV related head and neck cancer and over half reported “never” discussing it with their patients, in contrast to 70.9% who rated their education on cervical cancer as “good” or “excellent”, and 95% indicated a need for increased HPV education[21]; and

Whereas Studies have shown adults have a general lack of knowledge about HPV vaccinations and less than a third are aware of the association with non-cervical cancers, which has been associated with lower vaccination rates for themselves and their children[22,23]; and

Whereas, While current AMA policies (H-440.872 and H-370.995) address increasing physician and public education about HPV and cervical cancer, these current policies fail to explicitly address other HPV related cancers beyond cervical cancer, thereby potentially perpetuating prevalent misconceptions regarding the scope of HPV related cancers; and

Whereas, The Advisory Committee on Immunization Practices support removing barriers to vaccination access including offering immunizations in schools increasing access and follow up at appropriate intervals for patients that may have difficulty obtaining their vaccinations[25,26]; and

Whereas, While School-based HPV vaccination programs utilized in several other countries have resulted in the highest vaccination rates in the world, ranging from 69 to 90%, and large decreases in HPV related cancers, school-based HPV vaccination is rare in the U.S.[27,28]; and

Whereas, A Texas HPV vaccination education and administration program increased vaccination rates greater than HPV education alone by providing vaccinations to students and covering the cost by screening for insurance and covering uninsured students[29]; and

Whereas, Vaccine mandates to attend school are routine for communicable diseases including Hepatitis B for which 48 states mandate vaccination, while only 3 have HPV mandates[30,31]; and

Whereas, Physicians often present HPV vaccination as optional or non-urgent because it is not required for school entry which results in greater vaccination hesitancy among patients[32]; and

Whereas, AMA policy H-60.923 sets a precedent for supporting mandatory vaccination and H-440.970 states that nonmedical exemptions from immunizations endanger the health of the community at large and supports legislation eliminating such nonmedical exemptions; and

Whereas, Rhode Island mandates HPV vaccination for school attendance without explicitly permitting nonmedical exemptions which led to increased vaccine uptake compared to states that explicitly permit nonmedical exemptions, and funds this program at the state level by directly purchasing vaccines from the Centers for Disease Control at low costs to give to providers for free, thus eliminating financial barriers[16,33–35]; and

Whereas, Because screening for signs of non-cervical HPV related cancer is limited, vaccination is the primary method of cancer prevention, however, there has been evidence supporting the use of non-cervical cancer screening in high risk populations[36–38]; therefore be it

RESOLVED, That our AMA amend policy H-440.872 “HPV Vaccine and Cervical Cancer Prevention Worldwide” by insertion and deletion as follows:

HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872

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1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in both sexes such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA

(a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,

(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by:

(a) facilitating administration of HPV vaccinations in community-based settings including school settings, and

(b) supporting state mandates for HPV vaccination for school attendance, and be it further

RESOLVED, That our AMA work with appropriate stakeholders to promote educational resources on the relationship between HPV and all associated cancers and conditions, in addition to the HPV vaccination guidelines; and be it further

RESOLVED, That our AMA encourage gender-neutrality when educating and about HPV infection and promoting the HPV vaccine in order to normalize vaccination in all individuals; and be it further

RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.

Fiscal Note: TBD

Date Received: 08/27/2020

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RELEVANT AMA AND AMA-MSS POLICY

Meningococcal Vaccination for School Children H-60.923
Our AMA supports efforts to require that school children receive meningococcal vaccine per the Advisory Committee on Immunization Practices guidelines. Res. 414, A-14

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Childhood Immunizations H-60.969

1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. Res. 542, A-92CSA Rep. 4, I-95Reaffirmed by BOT Rep. 24, A-97Reaffirmation A-05Appended: Res. 121, A-13

Increasing HPV Education 170.008MSS

AMA-MSS will ask the AMA to:
(1) support specific teaching concerning transmission and sequelae in STD education; and

(2) reaffirm a commitment to specific AMA-MSS Digest of Policy Actions/ 39 HIV and general STD education. (MSS Sub Res 37, I-98) (Reaffirmed Existing Policy in Lieu of AMA Res 405, A-99) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula 170.011MSS

AMA-MSS will ask the AMA to strongly urge existing school health education programs to emphasize the high incidence of human papillomavirus and to discuss the importance of routine pap smears in the prevention of cervical cancer. (MSS Res 19, I-05) (AMA Amended Res 418, A-06 Adopted [D170.995]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Human Papillomavirus (HPV) Inclusion in School Education Curricula D-170.995

Our AMA will:

1. strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer;
2. urge that students and parents be educated about HPV and the availability of the HPV vaccine; and
3. support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers. Res. 503, A-07; Appended: Res. 6, A-12.

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b)

encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA: (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. Res. 503, A-07; Appended: Res. 6, A-12.

Insurance Coverage for HPV Vaccine D-440.955
Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;

(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and

(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations. Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16.

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations. CSA Rep. B, A-87Reaffirmed: Sunset Report, I-97Reaffirmed: CSAPH Rep. 3, A-07Reaffirmed: Res. 10, A-15Modified: CSAPH Rep. 1, I-15Appended: Res. 416, A-19

HPV Vaccine in Cervical Cancer Prevention Worldwide 440.028MSS

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AMA-MSS will ask the AMA to: (a) urge physicians to educate themselves and their patients about HPV vaccination;

(b) encourage the development and funding of programs targeted at reducing HPV transmission and screening for infection and precancerous cervical changes in developing countries;

(c) intensify efforts to improve awareness and understanding about the availability and efficacy of HPV vaccinations in the general public;

(d) encourage the integration of HPV vaccination into reproductive health care settings, including but not limited to routine reproductive health care visits for adults and adolescents; and

(e) support the availability of the HPV vaccine to patient groups that benefit most from preventative measures, including but not limited to low-income and pre-sexually active populations. (MSS Res 5, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

HPV Vaccination Access for Minors 440.038MSS
AMA-MSS will ask the AMA to develop and support model legislation allowing HPV vaccination consent by an unemancipated minor, independent of parental involvement. (MSS Res 42, I-11) (AMA Res 1, A-12 Referred) (Reaffirmed: MSS GC Report A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 027
(November 2020)

Introduced by: Joey Whelihan, University of Florida COM; Jerome Soldo, University of Louisville SOM; Austin Olano, Michigan State University College of Human Medicine; Avrohom Levy, Arizona College of Osteopathic Medicine; Pareena Kaur, Akshara Malla, University of Arizona COM-Phoenix; Jessica Mitter Pardo, Touro University California College of Osteopathic Medicine; Kimberly Lau, Niloufar Khanna, Leah Rae Uto, California Northstate University COM; Avery Keller Olson, University of South Dakota Sanford School of Medicine; Olivia A Lamonte, University of California San Diego COM; Haidn Foster, University of Cincinnati College of Medicine

Sponsored by: Region 4, Region 5, GLMA

Subject: Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas**,** Gender affirmation refers to the process of recognizing one's gender identity through social, psychological, and legal methods and may include medical interventions such as pubertal suppression, hormone therapy, and surgery[1]; and

Whereas**,** Gender-affirming healthcare refers to care that is sensitive, responsive, and affirming to transgender patients' gender identities and/or expressions[1]; and

Whereas**,** Transgender and gender-diverse (TGD) youth are at greatly increased mental health risks: for example, more than 50% of female-to-male transgender adolescents reported an attempted suicide, compared to 14.1% among all adolescents[2]; and

Whereas**,** TGD youth given gender-affirming treatment had lower lifetime odds of suicidal ideation as compared to those who desired but did not receive such treatment, decreasing rates of mental illness to those comparable to cisgender youth[3-5]; and

Whereas**,** Even though it is currently legal for physicians to provide gender-affirming care for TGD youth and adults, these groups already face significant barriers to receiving this care, such as a[6-7]; and

Whereas, The World Professional Association for Transgender Health (WPATH) and Endocrine Society suggest beginning medical pubertal suppression at Tanner Stage 2, which may even

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occur before the age of 10, and state that refusing timely gender-affirming care might prolong gender dysphoria[8-9]; and

Whereas, In 2020, at least eight state legislatures, including Missouri, Florida, Illinois, Oklahoma, Colorado, South Carolina, Kentucky, and South Dakota, have introduced legislation that would criminally punish physicians who follow evidence-based practices for treating adolescents with gender dysphoria[10]; and

Whereas, AMA policy H-65.965, Support of Human Rights and Freedom**,** opposes any discrimination based on an individual's sex, sexual orientation or gender identity[11]; and

Whereas, In May 2019, six leading medical organizations - the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association - issued a joint statement detailing opposition to "efforts in state legislatures across the United States that inappropriately interfere with the patient-physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in some cases, even criminalize physicians who deliver safe, legal, and necessary medical care"[12]; and

Whereas, Our AMA has spoken out on numerous occasions in opposition to state legislatures attempting to undermine the patient-physician relationship either through criminalizing healthcare decision-making or through censoring the content of physicians' counseling on topics like firearm safety or family planning options; and

Whereas, Our AMA has previously determined it prudent to specifically oppose the criminalization of medical care to populations that have been politicized in state legislatures, such as policy H-440.876, which supports the right of physicians to provide medical care to undocumented immigrant patients without fear of retribution; and

Whereas, Our AMA policy D-160.999 "Opposition to Criminalizing Healthcare Decisions" seeks to educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making", and the timely introduction of this resolution in the House of Delegates (HOD) further serves this purpose; therefore be it

RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria" by addition and deletion as follows:

> **Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927**
> Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as

outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

RESOLVED, This resolution immediately be forward to the House of Delegates for A-20.

Fiscal Note: TBD

Date Received: 08/01/2020

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12. Joint Statement from AAFP, AAP, ACOG, ACP, AOA, and APA. Frontline Physicians Call on Politicians to End Political Interference in the Delivery of Evidence Based Medicine. March 15, 2019. https://www.aafp.org/media-center/releases-statements/all/2019/physicians-call-on-politicians-to-end-political-interference-in-the-delivery-of-evidence-based-medicine.html

RELEVANT AMA AND AMA-MSS POLICY

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

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

Reaffirmed: CSAPH Rep. 01, I-18

Plan for Continued Progress Toward Health Equity H-180.944

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Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

BOT Rep. 33, A-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would **criminalize** or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.
2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Res. 402, A-12

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual’s birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual’s birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Res. 008, A-19

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Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Res. 010, A-17

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Reaffirmation: A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Modified: Res. 05, A-16

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when

creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Reaffirmation: A-19

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.
Res. 05, A-16

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 028
(November 2020)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Imaima Casubhoy, University of Missouri Kansas City; Jennifer Talbott, Mayo Clinic Arizona School of Medicine; Lauren Engel, Medical College of Wisconsin; Anna Heffron, University of Wisconsin School of Medicine and Public Health

Sponsored by: Region 2

Subject: Anti-Harassment Training

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The 2018 National Academies of Science, Engineering, and Medicine (NASEM) report on sexual harassment in academia defines sexual harassment as "composed of three categories of behavior: (1) gender harassment (verbal and nonverbal behaviors that convey hostility, objectification, exclusion, or second-class status about members of one gender), (2) unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include assault), and (3) sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity)", whether directly targeted towards an individual or ambient[1]; and

Whereas, Gender-based discrimination and bias are widespread in the medical professional workspace, with the rate of sexual harassment in academic medicine being close to double that of other engineering and science fields[2,3]; and

Whereas, Among female trainees, approximately 45% experience at least one instance of gender harassment through sexist hostility, and 18% have experienced crude, sexist behavior, and male trainees report 21% and 10% rates respectively[1]; and

Whereas, The 2018 NASEM report concludes that "the cumulative effect of sexual harassment is a significant and costly loss of talent in academic science, engineering, and medicine, which has consequences for advancing the nation's economic and social well-being and its overall public health"[1]; and

Whereas, Victims of sexual harassment often will not report the harassment to their institutions because of fear of retaliation such as being "labeled as a troublemaker"[4]; and

Whereas, The U.S. Supreme Court recognizes claims for sexual harassment as a form of discrimination based on sex under Title VII of the Civil Rights Act of 1964[5]; and

Whereas, The Equal Employment Opportunity Commission's Select Task Force on the Study of Harassment in the Workplace formed by the U.S. Equal Opportunity Employment Commission in their executive report stated: "The importance of leadership cannot be overstated – effective harassment prevention efforts, and workplace culture in which harassment is not tolerated, must start with and involve the highest level of management of the company[6]; and

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Whereas, *Sexual Harassment of Women: Climate, Culture and Consequences in Academic Science, Engineering and Medicine* states that "organizational tolerance for sexually harassing behavior" increases the risk of sexual harassment occurring within the organization[1]; and

Whereas, Sexual harassment in the professional environment leads to a well-documented loss of productivity and attrition of workers[1,7,8]; and

Whereas, A study published in *Academic Medicine* stated that it is imperative to have senior faculty and leadership call out inappropriate behaviors and sexual harassment to serve as role models for their colleagues, trainees, and staff[4]; and

Whereas, The American Association of Medical Colleges (AAMC) encourages a culture change as a way to address harassment, which includes training both men and women in bystander intervention;[3] and

Whereas, Real-world and experimental evidence shows that the way leadership communicates about sexual assault and sexual harassment strongly influences an organization or group's attitudes toward sexual harassment and violence, with leadership emphasis on addressing sexual harassment resulting in group participants who were surveyed on a Likert Scale to rate the priority of addressing harassment as .51 standard deviatons higher[9,10,11]; and

Whereas, Among those who do report sexual harassment to their employers, nearly half report being dissatisfied with the response[12]; and

Whereas, Given that the result of sexual harassment is a net loss of talent and highly-trained personnel, the costs of not aggressively addressing sexual harassment in medicine and organized medicine are substantial[1]; and

Whereas, Our AMA has a zero-tolerance policy for sexual harassment and expects members to act with decorum at meetings according to the Code of Conduct (H-140.837) and the AMA Code of Medical Ethics (9.1.3) explicitly states that sexual harassment is unethical, however there is no formal training in the AMA on how to prevent/counter sexual harassment or advise members when it occurs;[13] and

Whereas, Our AMA has demonstrated a financial commitment to reducing sexual harassment through previously utilizing outside resources to strenghten our AMA's policies and protections of all AMA members[14]; and

Whereas, Our AMA has created a CME module to address sexual harassment in medicine, especially between physicians and their patients[15]; therefore be it

RESOLVED, That our AMA require all members in elected and appointed AMA leadership positions to complete AMA code of conduct and anti-harassment training within one month of being elected; and be it further

RESOLVED, That our AMA work with Womens Physician Section, American Medical Womens Association, GLMA: Health Professionals Advancing LGBTQ Equality, Times Up Healthcare or other relevant parties and outside organizations to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership, and

RESOLVED, That our AMA shall distribute surveys and analyze the effectiveness of these trainings regarding both reduction in harassment in the AMA and leadership's confidence in their capabilities to reduce harassment for at least five years following initiation.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Policy on Conduct at AMA Meetings and Events H-140.837
It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

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2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA’s Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary

and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:
- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

9.1.3 Sexual Harassment in the Practice of Medicine
Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

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Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII

Advancing Gender Equity in Medicine D-65.989
1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946
Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972
It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

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Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence 515.002MSS
AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and support personnel providing legal medical services. (AMA Sub Res 215, I-93 Adopted [H-460.945]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 029
(November 2020)

Introduced by: Matthew J. Swanson, Frank H Netter MD School of Medicine; Vivian V. Altiery De Jesús, University of Puerto Rico School of Medicine; Rishab Chawla, Medical College of Georgia; Alex Butler, Columbia University Vagelos College of Physicians & Surgeons; Josh Bilello, University of Texas Medical Branch at Galveston; William Liakos, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Amrit Vasdev, University of Minnesota Twin-Cities; Madeline Drake, McGovern Medical School; Ayesha Firdous, University of Pittsburgh School of Medicine

Sponsored by: Region 2, Association of Native American Medical Students

Subject: Against Immunity Passports to Relieve COVID-19 Restrictions

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Policymakers are searching for novel ways to safely remove travel restrictions and social distancing mandates amidst the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus infectious disease-19 (COVID-19) pandemic[1]; and

Whereas, Immunity passports are currently defined by legal experts as digital or physical documents that certify an individual has been infected and is purportedly immune to SARS-CoV-2 and individuals in possession of such documents could be exempt from physical restrictions[1]; and

Whereas, Effective long-term immunity conferred by SARS-CoV-2 exposure, either by vaccination or infection, is not known[2,3]; and

Whereas, Immunity passports do not account for the possibility of SARS-CoV-2 reinfection even by those who have tested positive by the serological antibody test as we do yet not know what level of antibody titer is required for immunity[4,5]; and

Whereas, The United States and several other countries have proposed an immunity passport that certifies prior infection and immunity against SARS-CoV-2, which is misleading due to the difficulty in certifying immunity for a novel virus[1]; and

Whereas, Immunity passports would negatively impact vulnerable populations by decreasing liberty because of restricting mobility and opportunity for individual development (e.g. professional growth, leisure, relationships)[6,7]; and

Whereas, Immunity passports would increase health disparities and stigmatization by promoting infections among those who cannot access affordable vaccines[6,7]; and

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Whereas, Immunity passports would exacerbate social inequality by inequitable distribution of passports based on access to care and access to testing, and rationing of passports based on class[8]; and

Whereas, Immunity passports would introduce a new risk for discrimination if employers, insurance companies, law enforcement, and other powerful entities could access private health information for their own benefit[8]; and

Whereas, Immunity passports would pose considerable risk of corruption by privileging queues for infection certification and burdensome application processes, and risk of bias by creating restrictions on who can take part in social, civic, and economic activities[9]; and

Whereas, Immunity passports would incentivize individuals to seek out infection so that they may be relieved of restrictions, especially people who are unable to afford a period of workforce exclusion, compounding existing gender, race, ethnicity, and nationality inequities[9,10]; and

Whereas, The World Health Organization (WHO), European Centre for Prevention and Control (ECDC), International Air Transport Association (IATA), and International Civil Aviation Organization (ICAO) advocate against immunity passport implementation under present circumstances and test performance[11]; therefore be it

RESOLVED, That our AMA recognize that immunity passports have the potential to exacerbate racial, social and health inequities, stigmatization, and discrimination.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Ethical Use of Quarantine and Isolation Code of Ethics 8.4

The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to: (h) Ensure that quarantine measures are ethically and scientifically sound: § Use the least restrictive means available to control disease in the community while protecting individual rights; § Without bias against any class or category of patients. (i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting. (j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation. (k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease. (l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

Support for Public Health D-440.997

Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members, patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes. Our AMA recognizes the importance of timely research and open discourse in combating public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA i. Supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; ii. Supports legislation eliminating nonmedical exemptions from immunization; iii. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory

immunizations, including for childcare and school attendance; iv. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present; v. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and vi. Recommends that states have in place: i. An established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and ii. Policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations.

AMA Role in Addressing Epidemics and Pandemics H-440.835
Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) Non- immigrant travel into the United States not be restricted because of HIV status; and (3) Confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 030
(November 2020)

Introduced by: Maryssa Gilbert, Michigan State University College of Human Medicine; Gabrielle Guzzardo, Enrique Rodriguez-Fhon, Vikramjeet Saraan, Adjoa Kusi-Appiah, Michigan State University College of Human Medicine; Aquilla Chase, Loyola University Chicago Stritch School of Medicine; Manisha Verma, Central Michigan University College of Medicine; Nona Bhatia, Miriam Dow, Alivia Knol, Wayne State University School of Medicine; Bryn Thatcher, Sanuri Gunawardena, Wright State University Boonshoft School of Medicine; Bridget Dames, University of Toledo College of Medicine and Life Sciences; Akshay Patke, Benjamin Parker, Susmitha Kowligy, Chicago Medical School

Sponsored by: Region 2, Region 4, Region 5, Region 6

Subject: Mental Health First Aid Training

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In H-300.945, AMA endorses that all licensed physicians should become proficient in cardiopulmonary resuscitation (CPR) for medical emergencies, yet there is no such equivalent policy for acute mental illness crisis or substance use emergencies; and

Whereas, There are an estimated 46.6 million adults (about 1 in 5 Americans aged 18 or older) with a mental illness, and more than 20% (about 1 in 5) of children who have had a seriously debilitating mental disorder[1]; and

Whereas, There are 65.9 million physician office visits with mental disorders as the primary diagnosis annually[2]; and

Whereas, Primary care providers who had their own bias against mental illness were found to be less likely to refer patients to needed follow-up services for comorbid physical conditions, illustrating the need for additional education to ensure the parity of mental illness and physical illness[3]; and

Whereas, The number of behavior and mental illness-related visits in the Emergency Department has seen a 44% increase over the last decade; and despite this increase, there still remains a lack of compensatory mental illness education to meet the new demand[4]; and

Whereas, 59% of surveyed emergency medicine residents across the US felt that their program should have offered more psychiatric education in order to better equip them with tools on how to handle psychiatric emergencies of all kinds, as only 13% reportedly felt “well prepared” to do so[4]; and

Whereas, Mental Health First Aid (MHFA) is an internationally-recognized and evidence-based program that teaches how to assess and effectively respond to and support individuals

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developing or experiencing an acute mental illness or substance use crisis with concrete, context-specific first aid strategies in effort to safely mitigate harm to persons in our communities[5]; and

Whereas, United Kingdom medical students who underwent the eLearning course of MHFA showcased the potential to improve students' mental health first aid skills and confidence in helping others in crisis situations[6]; and

Whereas, Both online and face-to-face versions of MHFA have shown to improve outcomes for medical and nursing students with mental illnesses and has shown to provide utility for their future careers[7]; and

Whereas, MHFA training programs in the U.S. have been shown to increase knowledge of prevalence rates, cardinal signs and symptoms of common mental illness diagnoses, as well as building confidence to apply interventional skills[8,9,10]; and

Whereas, In a MHFA pre-survey, health care providers reported the same level of confidence when dealing with mental illness as compared to the general public[11], highlighting the relevant need for more evidence-based mental illness training education for medical personnel; and

Whereas, Mental illness education programs, such as MHFA, for health professionals showed an increase in supportive behaviors toward people struggling with mental illness, as well as decreased negative attitudes and stigma toward mental illness[12,13]; and

Whereas, Medical students who participated in additional mental illness education courses revealed favorable attitudinal changes of psychiatric services, human rights of the mentally ill, and patients' independence in social life[14]; and

Whereas, In 2016, US Congress HR 1877/S711 proposed authorization of $20 million for Mental Health First Aid Training programs to primary care professionals, students, emergency services personnel, police officers, and others with the goal of improving Americans' mental health, reducing stigma around mental illness, and helping people who may be at risk for suicide or self-harm and referring them to appropriate treatment[15]; therefore be it

RESOLVED, That our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to encourage awareness and access to evidence-based mental illness rescue training programs, such as Mental Health First Aid, for medical students and graduate medical education programs in all specialties; and be it further

RESOLVED, That our AMA work with appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state medical boards to provide access to evidence-based mental illness rescue training programs, such as Mental Health First Aid, as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
1. Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. CCB/CLRPD Rep 3, A-14

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. Res 412, A-06; Appended: Res 907, I-12; Reaffirmed in lieu of: Res 001, I-16

Awareness, Diagnosis, and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

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

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illnesses, and to increase patient access to quality care for depression and other mental illnesses.

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

4. Our AMA recognizes the impact of violence and social determinants on women's mental health. Res 502, I-96; Reaffirm & Appended: CSA Rep 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep 1, A-10; Modified: Res 301, A-12; Appended: Res 303, I-16; Appended: Res 503, A-17; Reaffirmation: A-19

Mental Health Crisis Interventions H-345.972
1. Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. Res 923, I-15; Appended: Res 220, I-18

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
1. Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. Res. 915, I-15; Revised: CME Rep 01, I-16

Statement of Principles on Mental Health H-345.999
1. Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.

2. The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the

mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.

3. The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.

4. The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field. A-62; Reaffirmed: CLRPD Rep C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep 1, A-09; Modified: CSAPH Rep 01, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: (A) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; (B) Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; (C) Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and (D) Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (A) be available to all medical students on an opt-out basis; (B) ensure anonymity, confidentiality, and protection from

administrative (C) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (4) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach. CME Rep 01, I-16; Appended: Res 301, A-17; Appended: Res 303, A-17; Modified: CME Rep 01, A-18; Appended: Res 312, A-18; Reaffirmed: BOT Rep 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983

1. Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression,

substance misuse and addiction, and suicide among physicians, residents, and medical students. CME Rep 06, A-19

An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses 345.002MSS

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

Stigmatization of Mental Health Disorders within the Medical Profession 345.004MSS

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

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 031
(November 2020)

Introduced by: Winona Gbedey and Cameron Holguin, UT Health San Antonio Long School of Medicine; Isabella Mak, University of Alabama at Birmingham; Amaryllis Fernandes, McGovern Medical School

Sponsored by: Region 3, Region 4

Subject: Supporting the Availability of Closed Caption in Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Disability, as defined by the Americans with Disabilities Act (ADA) of 1990, is a mental or physical impairment that substantially limits one or more major life activities as compared to most members of the general population [1]; and

Whereas, Research has found that concordances between patient and physician's race and ethnicity significantly enhanced the patient's healthcare experience, compliance and outcomes, yet little has been done to ensure the same for patients with disabilities [2,3]; and

Whereas, Patients with disabilities feel their doctors who don't have disabilities do not understand the realities of their struggles, yet the medical field has been slow to eliminate the barriers, including the lack of appropriate accommodations, that prohibit students with disabilities from entering the medical profession [4,5]; and

Whereas, Roughly five percent of American medical students reported having a disability in 2019, which, at a 64 percent relative increase since 2016, still grossly underrepresents the estimated 25 percent of adult Americans who live with disabilities [6,7]; and

Whereas, Section 504 of the Rehabilitation Act states that, at the postsecondary level, institutions are "required to provide students with appropriate academic adjustments and auxiliary aids and services that are necessary to afford an individual with a disability an equal opportunity to participate in a school's program" [1,8]; and

Whereas, A study published in 2016 found that 49 percent of the medical schools that were evaluated did not clearly state accommodation policies, many accommodation policies were difficult to locate, and some schools provided no information whatsoever, making them non-compliant with Section 504 of the Rehabilitation Act [9-11]; and

Whereas, Deaf and hard-of-hearing individuals over the age of 12 comprise 23 percent of the U.S. population and approximately 20 percent of young adults aged 20-29 have hearing damage due to noise, but only 1.2 percent of U.S. allopathic medical students and an unknown number of osteopathic medical students report having any sort of hearing impairment [6,12,13]; and

Whereas, Hearing loss is the most common physical and sensory disability encountered in medical schools, with accommodations ranging from sign language interpreters to stethoscopes

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that amplify heart and lung sounds, but closed captions, which provide full and equitable access to video content to individuals with hearing loss, are not a standard option [14,15]; and

Whereas, Closed captioning services are fairly simple and inexpensive to implement, because they can be competitively priced from vendors when purchased in high volumes, and institutions can purchase software, such as 'Dragon Naturally Speaking' or 'Camtasia', that supports real time voice-to-text transcription to automatically caption videos [16]; and

Whereas, Closed captions translate spoken language into written language and provide helpful clues to the person reading them by also identifying the person speaking, describing sound effects, and giving other relevant information [17]; and

Whereas, Even though closed captions were originally designed to aid individuals who were deaf or hard-of-hearing, a meta-analysis of over 100 studies has shown that captions also provide enormous benefits to student learners hoping to improve retention and comprehension, including those who are watching videos in a non-native language [17,18]; and

Whereas, Current research indicates that approximately half of undergraduate students use closed captioning, regardless of disability status, and of those students, two-thirds report that closed captions help them focus, retain information, and understand poor audio [16,17,19] ; and

Whereas, Our AMA-MSS has policies (295.211MSS and 310.055MSS) that support the use of assistive technology in the classroom for students, residents, and clinicians with disabilities, but the inconsistency across institutions nationwide shows the insufficient guidance on accommodations [9]; therefore be it,

RESOLVED, That our AMA collaborates with the AAMC, AACOM, and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including but not limited to lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY:

Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

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(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
Policy Timeline: CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA Rep. 06, A-18

A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929

Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training.
Policy Timeline: Res. 317, A-19

Improving Support and Access for Medical Students with Disabilities 295.211MSS:
AMA-MSS will ask the AMA to:
(1) Amend policy D-295.929 by addition as follows:
D-295.929 – A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees <u>and students</u> with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates <u>and students</u> with disabilities and challenges to employment after training <u>and medical education; and (3) work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms.</u>
(2) Amend policy D-90.991 by addition and deletion as follows:
D-90.991 – Advocacy for Physicians with Disabilities

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

Improving Support and Assistance for Medical Students with Disabilities 310.055MSS:
AMA-MSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM).
Policy Timeline: (MSS Res 33, A-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 032
(November 2020)

Introduced by: Mustfa Manzur, Oriana Pando, Allison Doermann, Maria Poluch, Wint M. Thu, Sidney Kimmel Medical College at Thomas Jefferson University; Emily Smith, Carle Illinois College of Medicine; Tsola Efejuku, University of Texas Medical Branch; Arvinth Sethuraman, Rutgers-New Jersey Medical School; Caroline Donahue, Daneka Stryker, Wiktoria Gocal, Drexel University College of Medicine; Amaryllis Fernandes at UTH McGovern Medical School

Sponsored by: Region 6, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Subject: Dissociating Race from Biology in Healthcare Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Race is a social construct defined by subjective interpretations of physical appearances, culture, and customs rather than inherent biology or genetics[1,2,3]; and

Whereas, Genetic ancestry can predispose individuals to certain disease states, such as cystic fibrosis, familial inherited amyloidosis, sickle cell anemia, and beta-thalassemia. These conditions have been strongly linked to genetics and race due to the nature of their inheritance pattern and location of origin[1,4,5]; and

Whereas, Genetic studies have shown that there is more genetic variation within rather than between socially defined racial groups. Furthermore, the Centers for Disease Control and Prevention (CDC) projects that “population of people who are ‘Two or More Races’ is projected to be the fastest growing racial or ethnic group over the next several decades[3,6]; and

Whereas, The descriptive categories of races vary between clinical sites and laboratories and race and ancestry are often conflated[7-9]; and

Whereas, Conflating race and genetically linked disease states can impact the care of an individual patient[8-11]; and

Whereas, Precision medicine can lead to more accurate risk profiles, diagnoses, treatments and better health outcomes for individuals patients[1,5,6,8-11]; and

Whereas, In the context of research and clinical practice, race is used as a proxy for other risk factors, such as environmental exposure, low socioeconomic status, impaired access to diverse and adequate nutrition, low educational attainment, poor housing conditions, chronic stress, and other social determinants of health (SDOH)[12-14]; and

Whereas, Racism is the fundamental link behind many of the aforementioned social and environmental determinants of health. For example, the lasting effects of historic segregation of blacks in the United States, such as mortgage discrimination, redlining, and restrictive

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covenants, has lead to impacts on access to education, high paying jobs, and health care, thus contributing to health inequities[11,14,15]; and

Whereas, Despite growing evidence that racism, instead of race, is the driver of health inequities, racism and its effects on health continue to be under studied[1,11,16]; and

Whereas, in light of the recent AMA Board of Trustees statement that racism is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care, emphasizing research on the effects of racism in medicine may provide more specific insight to health inequities and opportunity for advancement[17]; and

Whereas, Our AMA currently supports the use of race and ethnicity in research when interpreted correctly, and recommendations for using race in research have been proposed stating that in the interpretation of racial/ethnic differences, all conceptually related factors should be considered, including racism and discrimination, socioeconomic status (SES), social class, personal or family wealth, environmental exposures, insurance status, age, diet and nutrition, health beliefs and practices, educational level, language spoken, religion, tribal affiliation, country of birth, parents' country of birth, length of time in the country of residence, and place of residence (H-460.924); and

Whereas, How medical students are taught about systemic forms of inequities, such as racism, impact their desire to care for underserved populations and communities[9]; and

Whereas, Within medical education specifically, current Liaison Committee on Medical Education (LCME) language of addressing 'disparities' in healthcare (as opposed to inequities) reinforces medical students' persisting implicit biases that differences in health outcomes between black, indigenous, other peoples of color, and white people in the United States are due to biological differences, rather than rooted in the context of institutional racism[1]; and

Whereas, The current LCME standards are lacking content in regards to teaching both the differences and interdependence between structural inequities that create systemic disadvantage and SDOH that affect quality-of-life outcomes, an understanding of which is essential to achieving the LCME's aim of equipping students to address biases in themselves, in others, and in the healthcare delivery process[18,19]; and

Whereas, Medical students completing LCME-accredited curricula are unable to articulate cultural competencies and subsequently unequipped to act upon them while on clinical rotations, thus demonstrating the inadequate integration of these skills into medical school training and the need for specific antiracist pedagogy and evaluation[19,20]; and

Whereas, A recent survey of 29 medical schools reported a discordance between number of curriculum learning objectives geared towards SDOH and reported priority of teaching on this subject, with 34% of schools indicating the teaching of these topics is "low priority", indicating that this curricular area is in need of attention[21]; and

Whereas, Our AMA's Ed Hub continues to publish materials on systemic racism in relation to health outcomes during the pandemic but currently lacks modules or resources for educating students and faculty on related issues such as implicit bias and anti-racism training[22]; and

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Whereas, The current LCME standards do not require students to participate in service learning opportunities nor do they require experiential learning or assessment of antiracist and structural competency content[19]; and

Whereas, Current AMA-MSS policy encourages the LCME to implement various curricular requirements, including the addition of new content (65.101-MSS) as well as standardized, skills-based assessments of specialized medical education competencies, and further provide evidence on the efficacy of such modules and impacts on quality of patient care (295.122-MSS); and

Whereas, Current AMA and AMA-MSS policy encourages the LCME to assure that students have acquired and can utilize core clinical skills and further must pass an assessment on these skills (D-295.988 & 275.011-MSS); and

Whereas, Current AMA policy resolves to review the LCME's accreditation requirements to assure appropriate use of simulation education assessment in curriculum development and interprofessional education advancement (D-295.330); and

Whereas, Scholars acknowledge a dissonance among pedagogical approaches and mode of assessment in the preclinical and clinical undergraduate medical curriculum and guidelines (set forth by the LCME) translating into graduate medical training and eventual practice that engenders meaningful social change[21,23]; and

Whereas, 50-80% of health outcomes are determined by social, structural, and root cause factors outside of the clinical realm, requiring that a physician be equipped with the knowledge and praxis to address these factors in order to properly care and advocate for patients[24,25]; and

Whereas, Providers are more effective when trained in anti-racism strategies, structural racism, and their impact on health outcomes, thereby making each of these components essential professional competencies for practicing medicine[24,26,27]; therefore be it

RESOLVED, That our AMA encourages the dissociation of race from biology in healthcare curricula, textbooks, and educational materials by promoting the recognition of race as a social construct; and be it further

RESOLVED, That our AMA calls upon the AMA Foundation to repurpose a portion of existing funds on new scholarships, research grants, and awards to support outstanding academic and community efforts related to the impact of systemic racism on health; and be it further

RESOLVED, That our AMA calls upon the Liaison Committee on Medical Education (LCME) to revise its accreditation standards under Section 7.6 "Cultural Competence and Health Care Disparities" to: (1) change the current language from "disparities" to "inequities" and work with the AMA to update language ambiguity regarding the causes of health inequities, (2) identify systemic racism as the root cause of such inequities and require that curricula support the knowledge, skills, and core professional attributes needed to eliminate health inequities, and (3) require that medical students attending LCME-accredited institutions pass a school-administered cultural competency assessment and practicum to graduate from medical school; and be it further

RESOLVED, That our AMA will collaborate with national-level stakeholders across the various domains of healthcare education including (but not limited to): medicine, physician's assistant,

nursing, pharmacy, podiatry, dentistry, optometry, midwifery, technical, and public health on the issue of transitioning to dissociate race and biology in healthcare education and research; and be it further

RESOLVED, That our AMA will create and develop new modules and educational resources about systemic racism and its effects on health, including but not limited to anti-racism training, implicit bias training, advocacy, and interprofessional collaboration to broadly assist the education of healthcare students and faculty; and be it further

RESOLVED, That our AMA encourages the justification for any inclusions of race as a risk factor for disease states in healthcare educational material, and where appropriate, include the systemic injustices (particularly but not limited to racism) that contribute to the development of that disease; and be it further

RESOLVED, That our AMA-MSS will immediately forward this resolution to the I-20 AMA House of Delegates; and be it further

RESOLVED, That our AMA will report back to the House of Delegates at I-21 on the status of the resolved clauses above.

Fiscal Note: TBD

Date Received: 08/27/2020

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RELEVANT AMA AND AMA-MSS POLICY

Race and Ethnicity as Variables in Medical Research H-460.924

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Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98 Appended: Res. 509, A-01 Reaffirmed; CSAPH Rep. 1, A-11

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c)

supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLPRD Rep. 3, I-98 Appended and Reaffirmed; CSA Rep.1, I-02 Reaffirmed: BOT Rep. 4, A-03 Reaffirmed in lieu of Res. 106, A-12 Appended: Res. 952, I-17 Reaffirmed: CMS Rep. 10, A-19

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and

disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98 Reaffirmation A-01, Modified: CSAPH Rep. 1, A-11

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

Required Clinical Skills Assessment During Medical School D-295.988
Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills., and 2) require that medical students attending LCME-accredited institutions pass a school administered clinical skills examination to graduate from medical school.; and (3) ask that our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCMEaccredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams. (MSS Res 01, A-16 Immediate Transmittal) (AMA Res 321, A-16 Alternate Resolution 311, A-16 Adopted as Amended in Lieu of Res 311, 316, 317, and 321 [ ])
Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS
AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care AMA-MSS Digest of Policy Actions/ 12 by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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

Update on the Uses of Simulation in Medical Education D-295.330
Our AMA will:
1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;

2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;

3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;

4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;

5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 033
(November 2020)

Introduced by: Nikita Sood, Reyan Coskun Washington University in St Louis School of Medicine; Aaishwariya Gulani, University of Central Florida College of Medicine; Winona Gbedey, UT Health San Antonio Long School of Medicine; Roald Menodiado, Kansas City University of Medicine and Biosciences; Jada Ohene-Agyei, Imaima Casubhoy University of Missouri Kansas City School of Medicine; Isabelle Mawby, Northeast Ohio Medical University

Sponsored by: Region 3

Subject: Addressing Informal Milk Sharing

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, A growing body of evidence supported by the American Academy of Pediatrics (AAP) indicates that breast milk protects growing infants--especially preterm infants--against a variety of dangerous diseases and conditions, including bacteremia, urinary tract infections, lower respiratory tract infections, necrotizing enterocolitis, and sudden infant death syndrome, among others [1,2]; and

Whereas, Human milk sharing, also known as using donor human milk, provides access to breast milk for mothers who cannot provide enough for their infants, especially preterm infants in the Neonatal Intensive Care Unit (NICU) [3]; and

Whereas, Donor human milk provides nutrients comparable to a mother's own milk, yielding positive effects on neurodevelopment and tolerance of feedings, as well as reduced risk of sepsis and necrotizing enterocolitis, reduced length of stay in the NICU, and direct cost savings [4, 5]; and

Whereas, Informal or peer milk sharing, defined as the practice of donating or receiving donor human milk directly peer-to-peer, is growing in popularity, with tens of thousands of informal milk exchanges occurring via Facebook groups each year and national surveys of milk sharing participants finding that as many as 64% of respondents have obtained donor breast milk informally [6-11] ; and

Whereas, Informal milk sharing is associated with many quality concerns, such as dilution with non-human milk which infants are unable to properly digest for the first year of life [3, 12, 13]; and

Whereas, Informal milk sharing also carries many safety risks including contamination via infectious or toxic environmental agents, with several studies finding that a significant number of informally shared human milk samples were colonized with disease-causing pathogens, including aerobic bacteria, Gram-Negative bacteria, and coliform bacteria [14, 15, 16, 17]; and

Whereas, These safety risks are of special concern with the coronavirus disease 2019 (COVID-19) pandemic as it cannot be confirmed whether safety precautions known to protect against

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severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission—including wearing a mask while expressing milk, washing hands and equipment thoroughly, and pasteurizing donor milk—have been taken with informally shared milk [18, 19]; and

Whereas, Non-profit milk banks, which are regulated by the Human Milk Banking Association of North America (HMBANA), serve as a safe alternative to informal milk sharing by providing breast milk that is screened, pooled, tested, and pasteurized to be provided to infants in need [20]; and

Whereas, Non-profit milk banks are associated with many limitations in accessibility, including limited distribution as only 25 non-profit milk banks operate in the United States due to limitations in donor supply and access to funding [3, 21, 22, 23] ; and

Whereas, Already-limited milk supplies at non-profit milk banks are being further strained during the COVID-19 pandemic due to inadequate staffing, challenges with donor recruitment, and safety concerns about donor milk [24]; and

Whereas, Access to non-profit milk bank breast milk is also limited by cost, as this milk generally costs $3-$5 per ounce and though Medicaid; the Special Supplemental Nutrition Program for Women, Infants, and Children; and other aid-providing programs can help to cover costs, this coverage varies by state [25, 26] ; and

Whereas, The majority of the public is unable to access non-profit milk bank breast milk as a prescription is often required to receive this milk and the majority of non-profit milk bank breast milk is provided to NICUs due to limitations in supply [3, 27]; and

Whereas, Concerns have risen about informal milk sharing outcompeting milk banks for receipt of human milk donations and studies have found that women who participate in milk sharing are much more likely to have donated informally than to have donated to a milk bank [5-10, 28, 29]; and

Whereas, The AAP, the U.S. Food and Drug Administration, the European Milk Bank Association, HMBANA, and the Academy of Breastfeeding Medicine have released statements within the last 5 years discouraging informal milk sharing in favor of milk banking [3, 8, 9, 27, 30, 31]; and

Whereas, The American Medical Association (AMA) has existing policy supporting breastfeeding (H-245.982) and breast milk banking (H-245.972) but these policies and the policy statements they support make no mention of informal milk sharing or donation to milk banks; therefore be it

RESOLVED, That our AMA discourages the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; and be it further

RESOLVED, That our AMA encourages breast milk donation to regulated human milk banks instead of via informal means; and be it further

RESOLVED, That our AMA supports further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Breast Milk Banking H-245.972
Our AMA encourages breast milk banking.
Policy Timeline: Res. 443, A-07 Reaffirmed: CSAPH Rep. 01, A-17

Support for Breastfeeding H-245.982 AMA
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate

medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Policy Timeline: CSA Rep. 2, A-05, Res. 325, A-05, Reaffirmation A-07, Reaffirmation A-12, Modified in lieu of Res. 409, A-12 and Res. 410, A-12, Appended: Res. 410, A-16, Appended: Res. 906, I-17, Reaffirmation: I-18

Promoting Breastfeeding in Hospitals 245.013MSS

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AMA-MSS will ask the AMA to: (1) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; and (2) encourage hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice “rooming-in,” to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services.

Policy Timeline: (MSS Res 27, I-03) (AMA Amended Res 412, A04 Adopted [D-245.997]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-245.997 Rescinded: CCB/CLRPD Rep. 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)

Inclusion of Lactation Management Education in Medical School Curricula 295.073MSS

AMA-MSS encourages medical schools to incorporate lactation management education into the medical school curriculum where appropriate.

Policy Timeline: (MSS Rep D, A-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 034
(November 2020)

Introduced by: Peter Boules, Raveen Sugantharaj, Danny Luong, Marian University College of Osteopathic Medicine; Jordan Saunders, Lucy Brown, Sandra Jones, Faith Roberts, Sara Sims; Indiana University School of Medicine
Sponsored by: Region 5, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Subject: Improving Interracial Relationships and Inequity in Academic Medicine
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Of individuals enrolled in U.S. medical schools in 2019–2020, 50% identify as White, 22% Asian, 7% Black or African American, and 7% Hispanic, Latino, or of Spanish origin, in contrast to the general U.S. population of which 60% identify as non-Hispanic white, 6% Asian, 13% black or African American, and 18% Hispanic or Latino[1]; and

Whereas, Non-Hispanic African Americans represent 4.4%of all active post-graduate medical trainees ("residents"), compared to 42.7% being White residents[2]; and

Whereas, African Americans represent only 5.0% of employed physicians and 3.6% of full-time U.S. medical school faculty [3,4]; and

Whereas, Increasing racial diversity in American healthcare has been shown to be an important measure to help combat implicit bias by improving of societal perception of racial minorities[5] ; and

Whereas, Over 40% of medical school graduates report experiencing bias based on race, gender, or other personal trait [6, 7]; and

Whereas, Among professional Black adults, systolic blood pressure was 9 to 10 mmHg lower among those who reported that they typically challenged unfair treatment and who had not experienced racial discrimination [8]; and

Whereas, Unconscious biases that exist among mentors and mentees—whether based on gender, race, generation, or other characteristics—can hinder an institution's ability to study and address social change [9]; and

Whereas, The structure of graduate medical education programs ("residency programs") pose unique challenges to physicians of color, such as recurrent racial and ethnic biases at work and a lack of institutionalized programs to promote diversity within residencies [10, 11, 12]; and

Whereas, Minority residents and students are more likely to undertake additional responsibilities, such as serve as race or diversity ambassadors at their institutions, shoulder additional care for minority patients, or develop curricula to increase diversity and exposure[11]; an

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Whereas, After adjusting for confounding variables, both underrepresented minority (URM) and non-URM minority (e.g. Asian) students received lower grades than White students in most clerkships. These findings in addition to an evaluation of over 87,000 evaluation that link non-URM status as being viewed as more scientific and knowledgeable are highly suggestive that implicit racial bias plays a role in education and career advancement [6, 13, 14]; and

Whereas, Incorporation of underrepresented minorities to the medical student body and to the profession as a whole is highly correlated with increased educational benefit and cultural competency in addition to mental health benefits for the physician workforce [14, 15, 16]; and

Whereas, Research into cross-cultural competence achieved through longitudinal curriculums allows for equitable economic and health benefits for underrepresented populations in academic medicine, allowing for greater advancement and achievement in overall patient care [14, 17, 18, 19]; therefore be it

RESOLVED, That our AMA urge residency programs, irrespective of specialty, to track, report, and make publicly available race and ethnicity data at important aspects of graduate medical education (e.g., application, matriculation, graduation of residency, graduation of medical school, reports of discrimination) in order to improve transparency regarding diversity, cultural-competence and inclusion efforts; and be it further

RESOLVED, That our AMA record data on race and ethnicity in a self-reported, open manner, for example by allowing for specifiers that permit African-Americans to distinguish themselves as Black, Nigerian, or a subset of Afro Caribbean, rather than the current system which only records, “black, white, and latino”; and be it further

RESOLVED, That our AMA recommend that academic medical programs to retain a Chief Officer for Diversity, Equity, and Inclusion, Executive Associate Dean of Diversity, Equity, and Inclusion, or some other upper-level administrator whose responsibilities include but are not limited to mediating incidents pertaining to discrimination, creating race neutral policies, and advocating on behalf of minorities in medicine; and be it further

RESOLVED, That our AMA encourage the above mentioned programs to promptly adapt and make changes based on disparities and inequities identified through this reporting; and be it further

RESOLVED, That our AMA advocate for increased support of residency programs and rotations that incorporate longitudinal training on public health, including but not limited to training on healthcare inequities, social determinants of health, and improved cross-cultural relationships as they pertain to health care teamwork and education; and be it further

RESOLVED, That our AMA encourage institutions to consider the role of implicit bias in the promotion and retention of constituents.

Fiscal Note: TBD

Date Received: 09/20/2020

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Relevant AMA and AMA-MSS Policy

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.

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3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.

4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care, an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority: A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

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3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

65.005MSS Disseminating Information to Combat Ethnic Retaliation and Racism:

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

295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum:

AMA-MSS (1) recognizes that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

295.193MSS Implicit Bias and Its Effects on healthcare and Its Incorporation into Undergraduate Medical Education:

AMA-MSS (1) recognizes the existence of implicit bias among health care clinicians; (2) recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and (3) supports medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients. (MSS Res 07, I-17)

350.025MSS Racism as a Public Health Threat: AMA-MSS will ask the AMA to:

(1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the

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causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies. (MSS Res. 30, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 035
(November 2020)

Introduced by: Rishab Chawla, Medical College of Georgia; Neha Siddiqui, Carle Illinois College of Medicine; Samantha Pavlock, Florida State University College of Medicine; Rebecca Anderson, University of Nebraska Medical Center; Siri Sarvepalli, Wayne State University School of Medicine; Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Isabelle Yang, Sarah Matsunaga, Geisel School of Medicine at Dartmouth; Rajadhar Reddy, Baylor College of Medicine; Brittany Ikwuagwu, McGovern Medical School

Sponsored by: Region 2, Region 3, Region 5

Subject: Studying Population-Based Reimbursement Disparities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Certain specialties often care for a distinct population group of patients, such as pediatrics, OB-GYN, geriatrics, sports medicine, etc; and

Whereas, Lower reimbursements for certain specialities that care for particular patient populations may disincentivize physicians from entering those specialities or providing care for the corresponding patient populations; and

Whereas, Current AMA Policy (H-65.961) states that the AMA “declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics,” which can include the type of population a physician serves or the specialty they practice[1]; and

Whereas, The Medicare fee schedule is the main cause of reimbursement imbalance between specialties[2]; and

Whereas, Rotated seating of a given specialist on the RUC has been associated with a statistically significant increase in RVUs billed and compensation earned in that specialty[3]; and

Whereas, Relative to higher paid specialties, lower paid specialties with a single physician serving Medicare recipients are more likely to be completely absent in a given county; for example, 92% of counties lack an addiction medicine physician serving Medicare and 80% of counties lack an infectious disease specialist[4]; and

Whereas, Previously documented disparities in reimbursement by race showed statistically significant lower mean reimbursement per RVU for insured black patients within a tertiary hospital Emergency Department compared to their white counterparts, even after adjustment for demographic and insurance factors[5]; and

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Whereas, Medical school tuition rates are continually increasing, and as of 2019 the average medical student owes $200,000 in loans, a 2.7% increase from the year prior[6]; and

Whereas, Medical students have indicated difficulty in completing loan repayments due to lack of financial compensation as deterrents to entering certain fields and caring for certain populations[7,8]; and

Whereas, Specialties that care for certain populations of patients such as pediatrics and OB-GYN, are projected to be female-dominated fields[9]; and

Whereas, Procedures corresponding to certain patient populations are reimbursed at a lower rate than those of other patient populations[10]; and

Whereas, A 2017 study found a 37% gap in compensation for specialists between men and women: $345,000 vs. $251,000 for the same amount of work, highlighting potential gender reimbursement disparities[11]; and

Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that procedures predominantly done on men were associated with higher RVUs and compensated at a rate 26.67% higher than procedures done predominantly on women[10]; and

Whereas, RVUs reimbursed for procedures done predominantly on women have increased minimally from 1997 to 2015[10]; and

Whereas, Obstetrics and Gynecology (OB-GYN) physicians work comparable hours and perform many surgical procedures similar in number and complexity to other surgical specialities, yet their pay is the lowest amongst all surgical specialties[12]; and

Whereas, It has been estimated that there will be an OB/GYN physician shortage of 17%, 24%, and 31% by 2030, 2040, and 2050, respectively[13].

Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of internal medicine subspecialists, contributing to a high percentage of vacant seats across pediatric fellowship programs and a resulting shortage of pediatric subspecialists[14,15, 16]; and

Whereas, The compensation of pediatric endocrinologists has been found to be lower than that of general pediatricians, and pediatric infectious disease specialists experience the lowest compensation of all physicians, earning $191,735 compared to $265,000 earned by adult infectious disease specialists[17,18,19]; and

Whereas, Physicians who consider pediatric fellowships following completion of a non-primary care residency program, such as pediatric radiology, have reported lower perceived compensation relative to other fellowships as deterrents to entry, while pediatric ophthalmology continues to experience inadequate compensation and a substantial decline in interest as pediatric specialists face an earning potential that is half that of retina specialists[20,21, 22]; and

Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled seats; for example, 40.6% of pediatric nephrologist fellowship seats went unfilled in 2019[14]; and

Whereas, A shortage of pediatric subspecialists affects access to care through lower capacity and longer wait times for patients and their families, according to a 2017 study by the Children's Hospital Association[23]; therefore be it

RESOLVED, That our AMA study the root causes for reimbursement disparities among physicians who treat distinct patient populations but provide similar services, as well as reimbursement disparities for similar care performed on distinct patient populations.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Gender Discrimination in Medicine 9.5.5

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians. Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;

(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication. Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. BOT Rep. 27, A-19.

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work. Res. 010, A-18; Modified: BOT Rep. 27, A-19.

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

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2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population. CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18.

<u>Principles of and Actions to Address Primary Care Workforce</u> H-200.949

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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.

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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. CME Rep. 04, I-18.

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

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(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act. Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19.

Adequate Physician Reimbursement for Long-Term Care H-280.979

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting. Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) AMA-MSS Digest of Policy Actions/ 183 disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies; (2) which proprietary "correct coding" CPT bundling program is employed; (3) grievance and appeal mechanisms; (4) conditions under which a contract can be terminated by a physician or health plan; (5) patient confidentiality protections; (6) policies on patient referrals and physician use of consultants; (7) a current listing by name and specialty of the physicians participating in the plan; and (8) a current listing by name of the ancillary service providers participating in the plan. Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08 Reaffirmed: CMS Rep. 01, A-18.

Cuts in Medicare and Medicaid Reimbursement H-330.932

(4) if the **reimbursement** is not improved, the AMA declares the Medicare **reimbursement** unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and
(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care **reimbursement** programs, in addition to other needed payment increases. Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13.

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Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917
(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients. Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18.

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835
Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule. Res. 814, I-17.

RVS Updating H-400.969
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep.12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15.

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

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(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. BOT Rep. AA, I-88; Reaffirmed: I-92;

Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Non-Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services' Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17.

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946
Our AMA: (1) supports the use of decision support tools that aim to mitigate **gender** bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. Res. 005, A-18.

Rural Health H-465.989
180.003MSS Equitable Reimbursement for Physicians' Cognitive Services
AMA-MSS supports the concept that third-party payors should provide more equitable reimbursement for physicians' cognitive services. MSS Sub Res 7, A-84; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15.

525.011MSS Bridging the Gender Pay Gap
AMA-MSS (1) supports equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps. MSS Res 30 I-18.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 036
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville; Alyssa Greenwood Francis, Texas Tech Health Sciences Center El Paso; Jessyca Judge, Michigan State University College of Human Medicine

Sponsored by: N/A

Subject: Provision of Influenza Vaccinations, Treatment, and Screenings to Immigrants Held in Customs and Border Protection Facilities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, U.S. Customs and Border Protection (CBP) detained 859,501 people in short-term processing centers in 2019, but routinely holds people for longer than the expected time (72 hours or less) resulting in an increased risk for disease outbreaks such as influenza[1,2,3]; and

Whereas, CBP processing centers serve as the earliest point to provide influenza screenings, vaccinations, and treatment that would decrease the spread of the disease in other immigration facilities[4]; and

Whereas, The Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control (CDC) recommends all individuals six months and older to annually receive the influenza vaccine to reduce flu-related illness in the general population and flu-related hospitalizations and mortality in children[5,6]; and

Whereas, Children detained in processing centers are likely to be more vulnerable to the flu due to lower vaccination rates in their home countries and long-term detention once arriving in the United States[7]; and

Whereas, The CDC and U.S. Department of Health and Human Services (DHHS) recommended that all migrants who are present in these facilities for more than 24 hours should be offered an age-appropriate influenza vaccine or treatment[3,4]; and

Whereas, CBP has been urged numerous times by members of Congress and the chair of the House Appropriations Subcommittee, which oversees CBP and the Department of Homeland Security (DHS), to provide influenza vaccinations to those detained in their custody[8]; and

Whereas, The CDC also recommended that all staff at CBP facilities be provided with influenza vaccinations, although CBP recognized in a November 2019 letter that they still do not mandate that all employees receive the vaccine[4,8]; and

Whereas, CBP failed to follow either of the CDC's recommendations and instead argued that immigrants are vaccinated at other immigration facilities at later times, although many

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immigrants are immediately deported from CBP facilities, thereby eliminating the opportunity for them to vaccinated at another immigration facility[7,9]; and

Whereas, As a result of this failure to act, three children, ages two, six and 16, died in part due to influenza in U.S. Customs and Border Protection custody, which led physicians to write a letter to Congress recommending all children over the age of six months to receive the influenza vaccine as one of several steps to prevent flu-related mortality in these centers[7]; and

Whereas, Two of the three migrant children in CBP custody who died in part from influenza did not receive treatment or proper medical monitoring after their influenza diagnosis[10]; and

Whereas, The CDC recommended that immigrants who are suspected to have influenza symptoms be treated with antivirals as soon as possible[4]; and

Whereas, Our AMA urged the U.S. federal government to provide influenza vaccinations to asylum seekers in CBP custody, but has not similarly advocated for influenza treatment and respiratory related illness screenings[11]; and

Whereas, The language offered in this letter also failed to sufficiently take into account that not all immigrants are asylum seekers, and therefore excluded many at-risk individuals from the advocacy efforts that were made[11, 12]; and

Whereas, Our AMA has resolved to advocate for “patients at risk of pneumococcal or influenza infections receive the appropriate vaccination” (AMA Policy H-440.988); and

Whereas, Our AMA has resolved to advocate for adequate access to public health screening and age-appropriate medical care for immigrant children, regardless of legal status (AMA Policy H-350.957 D-60.968); and

Whereas, Our AMA has previously urged the U.S. Immigrations and Customs Enforcement Office of Detention Oversight to uphold its standard medical practices and increase immigrant access to health care (AMA Policy D-350.983); therefore, be it

RESOLVED, That our AMA advocates for the reduction of influenza related illness and mortality in Customs and Border Protection facilities through the following methods: 1) provision of timely influenza vaccinations to all detained immigrants, refugees, and asylum seekers, regardless of length of stay, and Customs and Border Protection personnel, 2) provision of evidence-based treatment for any immigrant, refugee, or asylum seeker with suspected or confirmed influenza, and 3) increased screening for influenza and other respiratory related illnesses in these facilities.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Distribution and Administration of Vaccines H-440.887

(1) It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record; (2) All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine

shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply; (3) Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate; (4) All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law; (5) Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician; (6) Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers; (7) Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community; (8) Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

Pneumococcal, Influenza, and Hepatitis-B Vaccines H-440.998
Our AMA advocates: (1) that patients at risk of pneumococcal or influenzal infections receive the appropriate vaccination; (2) that individuals, including health care professionals at high risk of hepatitis-B infection, be given the informed option of receiving HBV vaccine. Until further experience has alleviated concerns about possible late hazards from this vaccine, a more widespread usage is not currently justified; (3) study of possible solutions to the problems of payment for HBV and influenza vaccination for segments of the population at increased risk; (4) research to improve the efficacy of pneumonia and influenza vaccines in selected populations and to develop artificial HBV antigens, with a view to reducing the cost to patients of this important new vaccine; (5) physicians to follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention on the Prevention of Pneumococcal Disease; and (6) third party payers to appropriately reimburse physicians for the administration of recommended vaccinations.
Reaffirmed: Res. 520, A-02 Reaffirmation I-10

Reimbursement for Influenza Vaccine H-440.848
Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.
CSAPH Rep. 5, I-12

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Pandemic Preparedness for Influenza H-440.847
In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

Influenza Vaccine Availability and Distribution H-440.851
Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and

possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.

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

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

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

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Care of Women and Children in Family Immigration Detention H-350.955
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

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Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection.

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Improving Medical Care in Immigration Detention Centers 350.016MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full

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compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care.

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

Oppose Mandatory DNA Collection of Migrants 65.037MSS
AMA-MSS will ask the AMA to oppose the collection and storage of DNA of refugees, asylum seekers, and undocumented immigrants for non-violent immigration-related crimes without non-coercive informed consent.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 037
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville

Sponsored by: Region 1, Region 4

Subject: Amending D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages to identify and decrease barriers these student face in applying to medical school

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

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

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

Whereas, The total number of individuals with DACA status as of September 2019 is 652,880 people[2]; and

Whereas, 200 of the estimated 27,000 health care workers and support staff who depend on DACA for work authorization are medical students, residents, and physicians[3,4]; and

Whereas, Enrollment in, or completion of, high school or its equivalent in the US is required to receive DACA status, ensuring those with this status are as educated as US citizens[4,5]; and

Whereas, Some states continue to ban or limit enrollment to state sponsored postsecondary education to students who are not legal United States citizens[7]; and

Whereas, DACA-eligible individuals who pursue higher education, including undergraduate medical education, may bare more financial burden than others as they may not qualify for in-state tuition and federal aid or loan programs.[4,5,6]; and

Whereas, Many students with DACA status face uncertainty about their future legal status and therefore have difficulty applying to medical school[4,5,8]; and

Whereas, Students with DACA status who attend medical school could both serve to lessen the predicted physician shortage, and also provide a culturally diverse and bilingual physician workforce[4,5,8,9,10]; and

Whereas, The AMA has supported previous legislation preserving DACA status, along with filing an amicus brief in November 2019 that supports the Supreme Court upholding the legality of the DACA program[4,11]; and

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Whereas, The Supreme Court ruled on June 18, 2020 that the DACA program will be allowed to continue as is for now due to the fact that the Department of Homeland Security [DHS] did not follow proper protocol when attempting to end the program[12]; and

Whereas, Our AMA-MSS supports studying how DACA recipients can be incorporated into the physician profession (AMA-MSS Policy 295.185MSS) and supports the ability of individuals with DACA to receive a medical license (AMA-MSS Policy 275.015MSS); therefore, be it

RESOLVED, That our AMA amend policy D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages, by addition as follows:

> **Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages, D-350.986**
>
> 1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
> 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
> 3. Our AMA will work with appropriate stakeholders to identify and decrease barriers, including but not limited to those for undergraduate education and undergraduate medical education, faced by Deferred Action for Childhood Arrivals-eligible individuals who are applying to medical schools in the United States.

Fiscal Note: TBD

Date Received: 08/01/2020

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2. Deferred Action for Childhood Arricals (DACA) Data Tools. *Migration Policy Institute.* https://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles. Published on September 30, 2019. Accessed on March 14, 2020.
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4. Brief for Amici Curiae Association Of American Medical Colleges, et al., In support of respondents. Supreme Court of the United States.
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12. Department of Homeland Security et al. v. Regents of the University of California et al. Final Decision. Supreme Court of the United States. https://www.supremecourt.gov/opinions/ 19pdf/18-587_5ifl.pdf. Published on June 18, 2020. Accessed on August 1, 2020.

RELEVANT AMA AND AMA-MSS POLICY

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

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

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

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

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6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

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

Medical Licenses for Individuals with DACA Status 275.015MSS

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AMA-MSS will ask the AMA to 1) support the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses and 2) encourage state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states.

Continued Support for Diversity in Medical Education 350.011MSS
AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 038
(November 2020)

Introduced by: Jooeun Jeong, Brendan Grant, McGovern Medical School at University of Texas Health Science Center Houston; Hannah Todd, Rajadhar Reddy, Baylor College of Medicine; Samyuktha Melachuri, University of Pittsburgh School of Medicine; Amber Gautam, The Brody School of Medicine at East Carolina University

Sponsored by: Region 1, Region 3, Region 6

Subject: Health Coverage during States of Emergency

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The COVID-19 pandemic is an unprecedented crisis that has endangered the lives and healthcare coverage of Americans; and

Whereas, Two out of five working-age adults lack stable health coverage and more than 10 million Americans will lose employer-sponsored health insurance due to a pandemic-related job loss[1]; and

Whereas, Special Enrollment Periods (SEPs), enrollments outside the annual enrollment period, exist for the ACA marketplace due to life events such as loss of health coverage, loss of Medicaid/Medicare, and changes in household, residence, income, or incarceration status, amongst others[2]; and

Whereas, SEPs for ACA marketplaces have been used by many previously uninsured individuals to purchase private health insurance plans using federal subsidies; for example, in 2015-2016, 20% of ACA members enrolled during an SEP[3]; and

Whereas, Current regulations regarding marketplace enrollment will allow certain individuals, including those who have lost workplace insurance, to purchase coverage through their state or federal exchange; however, all others seeking to enroll may only participate during designated windows[4]; and

Whereas, Projections estimate that close to 600,000 newly unemployed Americans will enroll in the individual market after losing their jobs from the COVID-19 pandemic, and 3.5 million risk becoming uninsured[5]; and

Whereas, As of May 2020, the number of consumers gaining coverage through the HealthCare.gov Marketplace SEP for “loss of minimum essential coverage” was 43 percent higher than that in May 2019[6]; and

Whereas, All but one of the states with their own ACA health insurance exchanges opened their own SEPs in response to the uniquely challenging circumstances of the pandemic and the critical need for coverage[7]; and

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Whereas, In Maryland alone, whose coronavirus SEP lasted from March until mid-July, more than 50 thousand residents gained healthcare coverage[8]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) granted equitable relief in the form of extended enrollment period for Medicare Part A or Part B on March 17, 2020 and declared, as of May 5, 2020, that beneficiaries of Medicare Advantage and/or Part D who experienced enrollment issues from the COVID-19 pandemic would now be eligible to enroll under a SEP as part of the weather-related emergencies and major disaster declaration[9-11]; and

Whereas, We have seen a mix of legislative responses with the use of SEPs during the pandemic, and understanding efficacy of these responses could guide future policy; and

Whereas, The National Emergencies Act allows the President to declare of a national emergency, along with certain authorities to enact other legislative provisions during the time of a national emergency, which was done by President Trump for COVID-19 in March 2020[12,13]; and

Whereas, Section 1135 of the Social Security Act states that when the president declares an emergency under the Stafford Act or National Emergencies Act, the secretary of HHS is allowed to modify or waive certain Medicare and Medicaid eligibility requirements[14]; and

Whereas, The secretary of the HHS is allowed to make Medicare and Medicaid eligibility modifications at their own discretion such that there is no criteria that could automatically make a state eligible for these Medicaid modifications[15]; and

Whereas, The Federal Medical Assistance Percentage (FMAP) is the federal share of Medicaid funding that varies by state and is inversely related to each state's per capita income with a statutory minimum of 50 percent[16]; and

Whereas, Medicaid is a countercyclical program: Medicaid enrollment increases as the unemployment rate increases and state revenues decline, as seen by the increase of Medicaid enrollment by 2.3 million people from March 1st to May 1st, 2020 during the COVID-19 pandemic with further projected increases by 5 to 18 million people by the end of 2022[17-19]; and

Whereas, The American Recovery and Reinvestment Act (ARRA) of 2009 provided a temporary increase of 6.2 percent FMAP and an additional increase based on the unemployment rate of individual states, which prevented states from limiting Medicaid services or cutting other state programs[20]; and

Whereas, The Family First Coronavirus Response Act (FFCRA) of 2020 provides a temporary 6.2 percent FMAP increase during the public health emergency declared by the Secretary of Health and Human Services (HHS) for COVID-19, but does not provide additional FMAP increase based on individual state's unemployment rate[21]; and

Whereas, In the May 2020 letter to Congressional Leadership Regarding Medicaid Funding, the AMA advocated for enhancement of FMAP by at least 12 percentage points with additional support for those states hardest hit by the economic shockwaves[22]; therefore be it

RESOLVED, That our AMA investigate the recent use of Special Enrollment Periods during the COVID-19 pandemic to identify their potential impact in federal emergency response legislation; and be it further

RESOLVED, That our AMA advocate for the immediate expansion of Medicaid eligibility during national states of emergency; and be it further

RESOLVED, That our AMA collaborate with relevant subject matter experts and entities to develop model legislation for Federal Medical Assistant Percentage increases during a national emergency according to appropriate measures including, but not limited to, unemployment rates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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Health Insurance Affordability H-165.828
1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.

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11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

Redefining AMA's Position on ACA and Healthcare Reform D-165.938
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:
A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;
C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.

2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.

3. There will be a report back at each meeting of the AMA HOD.

Federal Medicaid Funding H-290.963
1. Our AMA opposes caps on federal Medicaid funding.
2. Our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

AMA Advocacy Efforts for Emergency Medicaid Funding and Assistance - Puerto Rico and the U.S. Virgin Islands D-290.975
1. Our AMA will urge and advocate the U.S. Congress to quickly pass legislation to adequately fund Puerto Rico’s and the U.S. Virgin Islands’ Medicaid Programs.
2. Our AMA will urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico and the U.S. Virgin Islands.

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

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Amended Res 703, I-04 [H-290.982]) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Report A, I-16)

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

Protecting Patient Access to Health Insurance and Affordable Care 165.019MSS
MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (MSS Late Res 01, I-16 Immediate Transmittal)

Expanding AMA's Position on Healthcare Reform Options 165.022MSS
AMA-MSS will ask the AMA to (1) rescind HOD policy H-165.844; (2) rescind HOD policy H-165.985; (3) amend by deletion HOD policy H-165.888 as follows: Evaluating Health System Reform Proposals H-165.888 1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: a. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs. ~~b. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.~~ c. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. e. And national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce and adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. g. All civilian federal

government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. h. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislations. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorder and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients; and (4) amend by deletion HOD policy 165.838 as follows: Health System Reform Legislation H-165.838 1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: (a) Health insurance coverage for all Americans; (b) Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; (c) Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; (d) Investments and incentives for quality improvement and prevention and wellness initiatives; (e) Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; (f) Implementation of medical liability reforms to reduce the cost of defensive medicine; (g) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens. 2. Our American Medical Association advocates that elimination of denials due to preexisting conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange by self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system; (c) Medicare payment cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted; (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; (f)

arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest. 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. ~~12. AMA policy is that creation of a new single payer, government run health care system is not in the best interest of the country and must not be a part of national health system reform.~~ 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (MSS Res 40, I-17) (AMA Res 108, A-18, Referred) (CMS Report 2, A-19, Not Adopt)

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

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 039
(November 2020)

Introduced by: Amaryllis I. Fernandes, McGovern Medical School at the University of Texas Health Science Center at Houston, Region 3

Sponsored by: Region 1, Region 3

Subject: Supporting HIPAA Coverage of Patient's Mobile Health Data

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Patients are increasingly using smartphones, health applications and wearable health technology to monitor vital signs, track health and medical conditions, and maintain a personal health record[1,2]; and

Whereas, Data collected by mobile health applications lacks regulated, standardized privacy and security requirements making it unclear who owns and has access to data or how user data is protected when being stored or transferred [3,4]; and

Whereas, Health applications have been found to share user data including health information with third party services such as Facebook or Google sometimes without disclosure in their privacy policies, impacting both patient privacy and potentially the consumer market [5-7]; and

Whereas, The sale or sharing of patients' personal health data by applications is not outlawed by the Health Insurance Portability and Accountability Act (HIPAA) as there is currently no policy pertaining specifically to mobile health applications used by individuals to manage their own health [8,9,10]; and

Whereas, The 2009 HITECH Act extended the HIPAA Privacy and Security rules to require businesses or third parties handling health information exchange to be held to the official standards but did not extend this coverage to technology companies who do not share their health data with healthcare providers[11,12]; and

Whereas, American Medical Informatics Association's (AMIA) 2017 policy action item list called for HIPAA or "HIPAA-like requirements" to be extended to non-covered mobile health entities, that will be handling patient health data[13,14]; and

Whereas, The Louisiana State Medical Society will be bringing forth a resolution at the A-20 House of Delegates Meeting to extend HIPAA-like requirements to non-covered mobile health entities which the MSS could support if we have relevant internal policy; and

Whereas, Our American Medical Association has passed policy (H-480.940) that supports safeguarding personal information and finding new ways to preserve patients' privacy interests as augmented intelligence (AI) in medicine continues to evolve but lack policy calling for the support of increased security of mobile health data[15]; and

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Whereas, Our AMA-MSS supports efforts to create guidelines for best practice standards concerning data security for genetic test results in medical settings and in direct-to-consumer contexts (460.024MSS), but does not have a policy that details support of increased, HIPAA-like protections for mobile health applications[16]; therefore be it,

RESOLVED, That our AMA-MSS supports HIPAA or HIPAA-like requirements for all mobile health applications and wearable health technology such that data collected by these applications and devices is afforded the same privacy protections as standard medical records.

Fiscal Note: TBD

Date Received: 08/01/2020

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16. American Medical Association MSS. 460.024MSS Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing. *MSS Dig policy actions | AMA*. 2019:146.

RELEVANT AMA AND AMA-MSS POLICY:

H-480.943: Integration of Mobile Health Applications and Devices into Practice

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

Policy Timeline: CMS Rep. 06, I-16 Reaffirmation: A-17

D-480.972: Guidelines for Mobile Medical Applications and Devices

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.

2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.

3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that

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can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.

4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.

5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.

6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.

7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.

8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.

Policy Timeline: CSAPH Rep. 5, A-14 Appended: Res. 201, A-15 Appended: Res. 305, I-16 Modified: Res. 903, I-19

H-480.940: Augmented Intelligence in Health Care

To that end our AMA will seek to: 3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the healthcare team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information. Policy Timeline: BOT Rep. 41, A-18

480.019MSS: Best Practices for Mobile Medical Applications
"That our AMA develop and publicly disseminate a list of best practices guiding the development of mobile medical applications" Policy Timeline: (MSS Res 10, I-14) (Reaffirmed: MSS GC Rep A, I-19)

480.018MSS: Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research:

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AMA-MSS will ask that our AMA study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (MSS Res 15, I-16) (AMA Res 509, A- 17 Existing Policy H-480.943 Reaffirmed in lieu of Res 509)

480.022MSS: Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications:
AMA-MSS will ask our AMA to amend policy D-480.972 to read as follows: Guidelines for Mobile Medical Applications and Devices D-480.972
(2) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
(4) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
(8) Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations. Policy Timeline: (MSS Res 10, A-19) (AMA Res. 903, Adopt as Amended [D-480.972], I-19)

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

460.024MSS: Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing:
AMA-MSS will ask the AMA to:
(1) Address Direct-to-Consumer genetic testing by amending H-460.908, Genomic-Based Personalized Medicine, as follows: H-460.908 – Genomic-Based Personalized Medicine. Our AMA:
… (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information; and
(4) will support efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts.
(2) Amend D-480.987, Direct-to-Consumer Marketing and Availability of Genetic Testing by insertion and deletion as follows:...(5) will work to educate and inform physicians and patients regarding the types, benefits and risks of genetic tests that are available directly to consumers, including, but not limited to… privacy violations, and company ownership of patient data.; so that patients can be appropriately counseled on the potential harms
(3) AMA-MSS will amend 200.019MSS, Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems by insertion as follows: (2) That our AMA encourage efforts

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to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts;
(4) AMA-MSS will ask our AMA to support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.
Policy Timeline: (MSS Res. 57, I-19)

MSS also formally supports HOD policy H-480.940: Augmented Intelligence in Health Care

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: …e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
…5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. Policy Timeline: (MSS Res 22, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 040
(November 2020)

Introduced by: Lauren Miller, Medical College of Wisconsin; Arvinth Sethuraman, Rutgers University New Jersey Medical School; Haris Qureshi, Anita Luxkaranayagam, University of Connecticut School of Medicine;

Sponsored by: Region 2

Subject: Support for the Establishment of Medical-legal Partnerships

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Social determinants of health such as employment, housing, transportation, and literacy are known to affect patients' overall health status and health outcomes[1]; and

Whereas, The incorporation of an expert in poverty law and administrative law into the healthcare team can reduce the difficulty patients experience when navigating the medical system's complicated policies and administrative barriers[2]; and

Whereas, Screening patients for social determinants of health without providing resources or treatment options is ineffective at addressing patient needs[3]; and

Whereas, Addressing social determinants of health cannot be done by the medical community in isolation, but will need changes in law and policy as well[4]; and

Whereas, Medical-legal partnerships (MLPs) are healthcare delivery models that combine health services and legal services to screen for and address social determinants of health[5,6];and

Whereas, MLPs provide opportunities for interprofessional collaboration to improve the delivery of healthcare and social services, and provide education for medical and legal trainees to screen for and address social determinants of health[5,7]; and

Whereas, MLPs seek to address the needs of patients regarding social determinants of health through identification of needs by physicians, and in response, providing social and legal support at the same location[6]; and

Whereas, MLPs have provided medical and legal services to general low-income population and specialized populations such as women and children[8]; and

Whereas, The most common needs MLPs address are: (1) income to assist patients in obtaining enough resources to meet basic needs of daily living, (2) housing and utilities to help patients access a healthy physical environment, (3) education and employment to help patients access opportunities to live and work,(4) legal status to assist patients in finding work, and (5) personal and family stability to reduce patients' exposure to violence at home[6]; and

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Whereas, The United States healthcare industry invested $2.5 billion into addressing social determinants of health from January 1, 2017 to November 30, 2019, yet only 22% of programs demonstrated an improvement of health outcomes, indicating that the investments are focused more on developing screening programs rather than directly addressing social determinants of health[9]; and

Whereas, Common barriers to implementing MLPs include lack of financial resources, lack of awareness regarding MLPs, and not prioritizing MLPs[10]; and

Whereas, MLPs addressing social determinants of health can improve healthcare quality, decrease disparities, and contribute to healthcare cost savings[11]; and

Whereas, MLPs can proactively address legal issues to prevent hospitalization and promote community wellness for at-risk patient populations[7]; and

Whereas, The American Association of Medical Colleges endorses MLPs as a method to have "significant, long-term impacts on local health inequities," and provides a framework of actionable goals for how MLPs can improve health outcomes[12]; therefore be it

RESOLVED, That our AMA-MSS support the expansion and development of medical-legal partnerships to better address social determinants of health.

Fiscal Note: TBD

Date Received: 08/01/2020

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2. "The Need," National Center for Medical-legal Partnership. (n.d.)
3. Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the Unintended Consequences of Screening for Social Determinants of Health. *Jama*. 2016;316(8):813. doi:10.1001/jama.2016.9282.
4. Commission on Social Determinants of Health, 2005-2008. World Health Organization, (2017)
5. "The Medical-Legal Partnership Toolkit. Phase I: Laying the Groundwork." *National Center for Medical-Legal Partnership*, (2015).
6. Teitelbaum JL, Wilensky SE. Social Determinants of Health and the Role of Law in Optimizing Health. In: *Essentials of Health Policy and Law*. 3rd ed. Burlington, MA: Jones and Bartlett Learning, LLC; 2017:123-134.
7. Tobin, E.T. Medical-Legal Partnership in Primary Care: Moving Upstream in the Clinic. *Am J Lifestyle Med*. 2017;13(3):282-291
8. Regenstein, M., Trott, J., Williamson, A. & Theiss, J. Addressing Social Determinants Of Health Through Medical-Legal Partnerships. *Health Affairs*. 2018;37(3):378-385
9. Horwitz, LI. et. al. Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19. Heath Affairs. 2020;39(2):192-198
10. Tsai, J., Jenkins, D. and Lawton, E., Civil legal services and medical-legal partnerships needed by the homeless population: a national survey. American Journal of Public Health. 2017;107(3):398-401.

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11. Matthew, D.B. “The Law as Healer: How Paying for Medical-Legal Partnerships Saves Lives and Money.” Brookings Institution (2020)
12. AAMC. Medical-Legal Partnership Logic Model (2015)

RELEVANT AMA AND AMA-MSS POLICY

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
BOT Rep. 39, A-18, Reaffirmed: CMS Rep. 10, A-19

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Res. 021, A-19

Support for Physician Led, Team Based Care D-35.985
Our AMA:
1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

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BOT Rep. 9, I-11 Reaffirmed: CMS Rep. 1, A-12 Reaffirmed: CMS Rep. 07, A-17 Reaffirmed: CMS Rep. 10, A-19

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942
(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective

cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.
CSA Rep. 4, A-96 Reaffirmation I-96 Modified by Res. 216, A-97 Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: BOT Rep. 1, A-08 Reaffirmed: CMS Rep. 07, I-16 Reaffirmed: BOT Rep. 16, A-19

Legal Protection and Social Services for Commercially Sexually Exploited Youth D-60.969
Our AMA will work with state medical societies and specialty societies to: (1) where appropriate, advocate for legal protection and alternatives to incarceration for commercially sexually exploited youth as an alternative to prosecution for crimes related to their sexual or criminal exploitation; and (2) encourage the development of appropriate and comprehensive services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth.
Res. 4, I-14

Providing Medical Services through School-Based Health Programs H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the

student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: Res. 412, A-05 Reaffirmed in lieu of Res. 908, I-12

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.
Res. 8, I-14

Expanding Access to Screening Tools for Social Determinants of Health 160.033MSS
AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. (MSS Res 03, I16) (AMA Res 711, A-17 Referred)

Recognizing Poverty-Level Wages as a Social Determinant of Health 440.063MSS
AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health. (MSS Res 37, A-17)

Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum 295.181MSS
AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H- 295.874]) (Reaffirmed: MSS GC Rep A, I-19)

Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students 295.141MSS

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(1) AMA-MSS will ask the AMA to recognize that inter- professional education and partnerships are a top priority of the American medical education system; (2) AMA-MSS will ask the AMA to explore the feasibility of the implementation of LCME and AOA accreditation standards requiring inter-professional training in medical schools. (MSS GC Report A, A-07) (AMA Res 308, A-08 Adopted as Amended [D-295.934]) (Modified: MSS GC Rep C, I-12) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 041
(November 2020)

Introduced by: Danielle Rivera, University of New Mexico

Sponsored by: Region 1

Subject: Opposition to Medical Bonding in Jail

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Medicaid and Medicare provide care to all U.S. Citizens, *except*, "with respect to care or services for any individual who is an inmate of a public institution" known as "The Inmate Exception Rule"[1]; and

Whereas, 'The Inmate Exception Rule' does not distinguish between inmates who are held pre- or post- conviction[1,2]; and

Whereas, Persons who are arrested and booked in jail can be held there before trial due to an inability to post monetary bail or a judge's decision to deny release[2]; and

Whereas, Persons detained pretrial are innocent until proven guilty[3]; and

Whereas, Because of the aforementioned Inmate Exception Rule, persons who are detained pretrial lose access to social safety net services, including Medicaid and Medicare, before they have the opportunity to have a trial[1,2]; and

Whereas, The healthcare of inmates in jail is paid for by the county, city, or municipality which runs the jail[4,5]; and

Whereas, Medical bonding is the practice of releasing detained inmates while they are having a severe medical crisis[6]; and

Whereas, The practice of medical bonding occurs in at least 25 states[7]; and

Whereas, Medical bonding requires requesting a bond from a judge prior to allowing the inmate to receive care at a hospital, further delaying access to medical care during a medical emergency due to financial concerns rather than medical concerns[7]; and

Whereas, Reports have noted in at least one instance, a patient was handed a pen to sign for his release while in and out of a diabetic coma and has no memory of ever signing the bond[7]; and

Whereas, After recovery, medically bonded inmates are frequently rearrested indicating that it was only medical cost that warranted their initial bond[7]; and

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Whereas, Medical care in jail is frequently poor and the practice of medical bonding is often subsequent to substandard care in jail[7]; and

Whereas, After being bonded out, jails are not responsible for the bonded inmates' healthcare costs[6,7]; and

Whereas, Jails are using medical bonding to avoid providing and paying for adequate medical care for inmates, or to avoid paying for health care for those who cannot be treated within the jail health care system[6,7];

Whereas, Current AMA policy D-430.977 calls for the improvement of healthcare services in detention facilities; and

Whereas, Current AMA policy H-430.986 already supports the processing of Medicaid applications for persons while they are incarcerated; therefore be it

RESOLVED, That our AMA-MSS advocate against medical bonding practices being used to abdicate responsibility for captive populations' healthcare.

Fiscal Note: TBD

Date Received: 08/01/2020

References:

1. Social Security Act. 1965. https://www.ssa.gov/OP_Home/ssact/title19/1905.htm. Accessed March 14, 2020.
2. Wachino, Vikki. To facilitate successful re-entry for individuals transitioning from incarceration to their communities. Centers for Medicare and Medicaid Services. Accessed April 28, 2016. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf. Accessed March 14, 2020.
3. *Coffin v. United States*. 1895. https://supreme.justia.com/cases/federal/us/156/432/. Accessed March 14, 2020.
4. What is the Difference between Jail and Prison? Prison Fellowship. Accessed March 14, 2020.
5. Federal Policy Impacts on County Jail Inmate Healthcare & Recidivism. National Association of Counties. March 2019. Accessed March 14, 2020.
6. Sheets, Connor. An Inmate Needed Emergency Medical Help. The Jail's Response: See if She Has Insurance. October 1, 2019. https://www.propublica.org/article/an-inmate-needed-emergency-medical-help-the-jails-response-see-if-she-has-insurance. Accessed March 14, 2020.
7. Sheets, Connor. Alabama Sheriffs Release Sick, Dying Inmates from Jail to Avoid Paying their Hospital Bills. https://www.al.com/news/2019/09/alabama-sheriffs-release-sick-dying-inmates-from-jail-to-avoid-paying-their-hospital-bills.html. Accessed March 14, 2020.

RELEVANT AMA AND AMA-MSS POLICY

Support for Health Care Services to Incarcerated Persons D-430.997

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Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;

(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion. Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00 Reaffirmation I-09 Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16 Appended: Res. 421, A-19 Appended: Res. 426, A-19

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

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6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. CMS Rep. 02, I-16 Appended: Res. 417, A-19 Appended: Res. 420, A-19 Modified: Res. 216, I-19

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes. Res. 408, A-18

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 042
(November 2020)

Introduced by: Rebecca Anderson, Rohan Khazanchi, Ellie Blusys, Jacey Hilbers, University of Nebraska Medical Center; Jarrett Campbell, Indiana University School of Medicine; Ellena Popova, Perelman School of Medicine-University of Pennsylvania
Sponsored by: Region 2, Region 6, GLMA

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The World Health Organization has unequivocally defined infertility as a disease state and cause of disability[1]; and

Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for transgender men, which can suppress ovulation, and estrogen therapy for transgender women, which can lead to impaired spermatogenesis and testicular atrophy[2,3]; and

Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and oophorectomy, which results in permanent sterility[2,3]; and

Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of respondents had received GAHT and 25% had undergone some form of GAS[4]; and

Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Society for Reproductive Medicine (ASRM) all recommend that transgender individuals receive counseling regarding potential loss of fertility and future reproductive options before initiating GAHT or undergoing GAS[5–7]; and

Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care Act created protections barring insurance discrimination based on sexual orientation and gender identity, although the current Administration has declined to defend this regulation and has been deferential to states[8–10]; and

Whereas, Employers and states that have implemented coverage of transition-related services have demonstrated minimal or no costs with vast immaterial/societal benefits[10,11]; and

Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of economic benefit, it is still difficult for transgender patients to obtain insurance coverage for gender-affirming care, fertility counseling, and gamete preservation[3,4,12]; and

Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with specific requirements determined on a state-by-state basis[12,13]; and

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Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around qualifying diagnoses is variable between states[12,13]; and

Whereas, "Iatrogenic infertility" has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes[12]; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient's physician (H-185.950)[7,14]; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is "caused directly or indirectly by necessary medical treatments as determined by a licensed physician" (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our AMA will amend policy H-185.990 by insertion as follows:

> **Infertility and Fertility Preservation Insurance Coverage H-185.990**
>
> It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician<u>; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility</u>.

RESOLVED, That our AMA will amend policy H-185.950 by insertion as follows:

> **Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Right for Gamete Preservation Therapies H-65.956
It is the policy of the AMA that (1): Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and (2) Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Infertility and Fertility Preservation Insurance Coverage H-185.990
It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Res. 150, A-88 Reaffirmed: Sunset Report, I-98Reaffirmed: CMS Rep. 4, A-08Appended: Res. 114, A-13Modified: Res. 809, I-14

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.
Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122 A-08; Modified: Res. 05, A-16

Infertility Benefits for Veterans H-510.984
The AMA (1) Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; (2) Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; (3) Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; (4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden

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of infertility among service women.
CMS Rep. 01, I-16Appended: Res. 513, A-19

Infertility and Infertility Insurance Coverage 420.010MSS
AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons.
MSS Res 24-I-17

Storage & Use of Human Embryos- Ethics 4.2.5
Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:
(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
(b) Made available to other patients for purposes of reproduction.
(c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
(d) Allowed to thaw and deteriorate.
(e) Otherwise disposed of.
Under no circumstances should physicians participate in the sale of stored embryos

Assisted Reproductive Technology- Ethics 4.2.1
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. "Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.

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(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.blished guidelines and self-regulation.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 043
(November 2020)

Introduced by: Emily Smith, Carle Illinois College of Medicine; Jara Crawford, Indiana University School of Medicine; Minji Kim, University of Miami Miller School of Medicine; Sanjay Jinka, Northeast Ohio Medical University; Hallie Walther, University of Kentucky College of Medicine.

Sponsored by: Region 2, Region 4, Region 5

Subject: Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a baby's life[1,2]; and

Whereas, Breast milk has established benefits for the baby, including reduced risks of infection, such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established benefits of breastfeeding and breast milk expression for the mother, including reduced risk of breast and ovarian cancer, type 2 diabetes mellitus, and hypertension[1,2,3,4]; and

Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities, increased brain development in children, and improved mother-child relationship[5]; and

Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the health of both the mother and infant[6]; and

Whereas, The cost of infant formula is up to $1,500 per year, and if infants take 25 ounces per day, formula costs an average of $0.16 per ounce; alternatively, feeding a baby with pasteurized donor human milk costs an average of $4.50 per ounce[7,8,9,10,11]; and

Whereas, The cost of healthcare in a breastfed baby's first year of life is, on average, at least $331 less than a formula-fed baby[9]; and

Whereas, Informal milk sharing is advised against by the AAP, the U.S. Food and Drug Administration, the Human Milk Bank Association of North America, and the European Milk Bank Association due to the risk of bacterial or viral contamination and the lack of appropriate screening for unsafe medications or drugs present in the milk[12,13,14,15]; and

Whereas, A woman's right to breastfeed or express breast milk in any private or public location is protected by law in all fifty states of the United States; however for mothers in prison, there are significant barriers to expressing and storing breast milk, such as requiring presence of a prison guard, time restrictions, and insufficient equipment[16,17]; and

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Whereas, 3.8% of newly admitted women to U.S. prisons are pregnant, and 92% of pregnancy outcomes in prisons resulted in live births[18,19]; and

Whereas, 25% of justice juvenile residential facilities (JJRF) house at least one pregnant youth, and assuming that each JJRF has one pregnant youth, 2.1% of all adolescent females in JJRFs are pregnant[20]; and

Whereas, Most women who give birth while incarcerated are separated from their child after hospital discharge and usually without sufficient education on breastfeeding[21]; and

Whereas, The separation of a mother and newborn compromises the psychological health of the mother and the newborn, including stress in the child that can have long term detrimental effects[22,23,24,25,26]; and

Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while incarcerated will decrease their milk supply, hindering their ability to directly breastfeed their child once released from incarceration[27]; and

Whereas, One jail facility in New York with a nursery program allowed women to bond with their newborns through breastfeeding and had a positive contribution to their maternal identity[28]; and

Whereas, In 2017, the National Commission on Correctional Health Care called on correctional facilities to support programs for incarcerated postpartum women to breastfeed their babies directly or pump breast milk and store it for later delivery to the infant[29]; and

Whereas, The protections for incarcerated mothers to express milk may be established on a state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington have laws offering protections, although still with limitations[16,30,31,32,33,34,35]; and

Whereas, The American Medical Association (AMA) has a policy (H-430.997) stating that "correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards"; and

Whereas, The AMA has policies in support of breastfeeding (H-245.982) and bonding programs for women prisoners and their newborn children (H-430.990), but these policies do not specify protecting an incarcerated mother's right to express milk; therefore be it

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

> **Bonding Programs for Women Prisoners and their Newborn Children H-430.990**
>
> Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. <u>However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends</u>

the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate Resolution RS-056 (I-20) Page 5 of 6 medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written

breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Policy Timeline: CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

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Policy Timeline: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Policy Timeline: Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09 Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Protecting a Mother's Right to Breastfeed 245.011MSS
AMA-MSS supports state legislation that clarifies and enforces a mother's right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother's right to breastfeed in a public place.

Policy Timeline: MSS Res 15, A-02; Reaffirmed: MSS Rep C, I-07; Reaffirmed: MSS GC Report C, I-12; Reaffirmed: MSS GC Report A, I-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 044
(November 2020)

Introduced by: David Long, Laila Koduri, Jonathan Paul, Tina Reddy, Tulane University; Rijul Asri, Arvinth Sethuraman Rutgers University

Sponsored by: Association of Native American Medical Students

Subject: Advocate for the Legalization of Recreational Cannabis to End Mass Incarceration

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Racial minorities are more likely to be arrested for drug- and alcohol-related crimes[1], even when adjusted for greater rates of drug and alcohol use, and were more likely to be arrested, convicted and imprisoned rather than cited and released at both the felony and misdemeanor levels, findings that hold true in every U.S. state[2-4];

Whereas, Youth as well as adults, with a personal history of incarceration have increased rates of chronic medical conditions[5], Sexually Transmitted Infections, substance abuse disorders, and mental health disorders[6-8]; and

Whereas, Although prisons provide healthcare for inmates, incarcerated individuals receive improper or inadequate access to healthcare[9]; and

Whereas, Poor mental health either during incarceration or following release is associated with greater risk of recidivism[10]; and

Whereas, Adverse health outcomes during and following incarceration extend to the family of the incarcerated individual[11]; and

Whereas, Children of incarcerated parents experience greater rates of mental and behavioral issues, including substance use in childhood and adulthood, and families face additional financial hardships due to lack of income[6]; and

Whereas, Incarceration during pregnancy is associated with a similar increase in risk of adverse child and maternal health outcomes as seen in pregnant women with “high levels of intersecting stressors” outside of prison[12]; and

Whereas, The burdens of mass incarceration have been disproportionately borne by Black Communities[13,3]; and

Whereas, Current levels of mass incarceration exacerbate the spread of COVID-19 due to overcrowding and substandard hygienic care, and may be disproportionately affecting minority inmates[14]; and

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Whereas, Cannabis is considered a Schedule I drug under the Controlled Substances Act of 1970[15]; and

Whereas, Our AMA's Council on Scientific and Public Health have recently released a report on cannabis use which relied on the National Academies of Science, Engineering, and Medicine's 2017 report[16], which found "conclusive or substantial evidence that cannabis or cannabinoids have some therapeutic benefits;" and

Whereas, The individual adverse health effects of recreational cannabis use are reversible with discontinuation of use for most adults[17]; and

Whereas, Legalization of cannabis in states such as Colorado and Washington has not increased the rate of cannabis use among youth[18,19]; and

Whereas, Studies and data from states that have legalized recreational cannabis have shown that legalization alone does not cause additional harm to the public or increase public health expenditures[20-22]; and

Whereas, In Colorado the greater than $1 Billion USD[22] revenue generated from taxation of cannabis products has been directed toward education, public health, and other community based programs[23]; and

Whereas, Taxation of recreational cannabis can provide funding for projects aimed at preventing and reducing harm of the following ongoing public health issues: cannabis use during pregnancy[24,25], driving while intoxicated[26], and youth cannabis and other drug use[18,19]; and

Whereas, Benefits of legalization of recreational cannabis seen in Colorado and Washington include reduced financial burden of drug enforcement[20], reduced opioid mortality[27], and no increase in traffic-related incidents[28,29]; and

Whereas, Our AMA commits itself to evidence-based decision making and practices in fulfilling its duty to the public good, and in doing so, "encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality, [and also] supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons (H-350.974);" and

Whereas, Our AMA "supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use (H-95.924);" and

Whereas, Our AMA "urges that [cannabis'] status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines," (H-95.952) and supports legal protection of physicians who "recommend cannabis in accordance with their state's laws" (D-95.969); and

Whereas, Cannabis and its derivatives have valid medical uses including but not limited to chronic pain management, management of chemotherapy side effects, and treatment of epilepsy, irritable bowel syndrome, ALS, and anorexia, which invalidates its status as a Drug Enforcement Agency (DEA) Schedule I substance with "no currently accepted medical use"[30]; therefore be it

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RESOLVED, That Our AMA amend current policies H-95.924, H-95.952 and D-95.969 as denoted below:

Cannabis Legalization for Recreational Use H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) ~~believes that the sale of cannabis for recreational use should not be legalized;~~ (2) (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (8) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (9) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and (10) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. 2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. ~~This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.~~ 3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving

cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. 4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. ~~5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. 6.~~ 5. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.~~ 7.~~ 6. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; ~~(2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3)~~ (2) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has ~~a high~~ potential for abuse~~. This product~~ Tetrahydrocannibinol, its major active ingredient, has ~~not~~ been approved by the Food and Drug Administration for preventing or treating ~~any~~ only certain disease process."; ~~(4)~~ (3) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; ~~(5)~~ (4) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; ~~(6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians~~; and ~~(7)~~ (5) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved

cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Cannabis Legalization for Recreational Use H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (8) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (9) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and (10) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. 2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. 3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. 4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women

who are breastfeeding. 5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. 6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids. 7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Addiction and Unhealthy Substance Use H-95.976

Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction; (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services; (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals; (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use; (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention

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strategies; (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences; (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and (8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

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95.003MSS
Marijuana: Medical Use and Research: AMA-MSS will ask the AMA to support reclassification of marijuana's status as a Schedule I controlled substance into a more appropriate schedule. (MSS Res 2, A-08) (AMA Res 910, I-08 Referred) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

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

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

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

95.009MSS
Addressing Emerging Trends in Recreational Drug Abuse: That our AMA (1) support the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse. (MSS Res 16, A-14) (Substitute AMA Res 901, I-14 Adopted with Change in Title [H-95.940]) (Reaffirmed: MSS GC Rep A, I-19)

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 045
(November 2020)

Introduced by: Shyon Parsa; Whitney Stuard, The University of Texas Southwestern; Alexander Butler, Columbia University Vagelos College of Physicians and Surgeons; Ayesha Firdous, University of Pittsburgh; Amrit Vasdev, University of Minnesota-Twin Cities; Shefali Jain; Amanda Myles, Medical College of Georgia at Augusta University; Adrian Falco, Texas Tech HSC School of Medicine; Adam Saleh, Texas A&M HSC School of Medicine; Mir Ali, The University of Texas Southwestern.

Sponsored by: N/A

Subject: Supporting Medical Student Physician Shadowing in a Remote Capacity During the Current Crisis

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Shadowing is considered an important step in becoming a physician for its role in fostering professional development, stimulating interest in certain specialties, and helping to develop empathy[1,2,3,4]; and

Whereas, Shadowing provides for increased rates of interprofessional interactions which allow students to achieve more Interprofessional Education Collaborative (IPE) core competencies[5]; and

Whereas, Physician mentorship and shadowing has been associated with an 82% increase in students aiming to become leaders in medicine and 96% of medical students reporting they hope to shadow again[6,7]; and

Whereas, One of the important factors in pursuing a medical career has been time exposed to the field, positive role models in medicine, and positive rotation experience[8]; and

Whereas, Total cases of COVID-19 have been growing with new cases being introduced each day[9]; and

Whereas, AAMC recommendations indicate that medical school students aiming for clinical experience outside of core clinical curriculum during the COVID-19 pandemic should only do so to address local healthcare needs, which excluded shadowing experiences[10]; and

Whereas, The loss of clinical experiences and shadowing opportunities due to the pandemic have led to a marked increase in virtual learning resources made available to clinical students, including but not limited to Zoom, smartphone/tablet use, and telemedicine[11,12,13]; and

Whereas, Telemedicine technology is defined as the use of electronic information or telecommunication technology in order to support patient and provider health-related education[14]; and

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Whereas, Use of these technologies for undergraduate, postgraduate, and continuing medical education has become increasingly prevalent[15]; and

Whereas, Numerous studies have highlighted the efficacy of virtual learning through various modalities including anatomical dissections, patient cases, and simulation based learning[16,17,18,19]; and

Whereas, Other clinician training programs in the United States have successfully implemented virtual shadowing opportunities for their students due to the current COVID-19 pandemic[20,21]; therefore be it

RESOLVED, That our AMA-MSS support the use of telemedicine technologies for use by pre-medical and medical students for the purpose of physician shadowing.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Guidelines for Student Shadowing Physicians H-295.859

Our American Medical Association: (1) encourages physicians in both private practice and academic settings to provide **shadowing** opportunities to students interested in a career in medicine--particularly those from underrepresented populations--as part of the physician's commitment to the future of the profession; (2) encourages physicians to adopt the most appropriate **shadowing** model to the needs of the practice/institution and the student(s); and (3) endorses the clinical **shadowing** guidelines for students from the Association of American Medical Colleges as one model for such students and will help disseminate this document to K-12 students, premedical students, health professions advisors, hospitals, and physicians.

CME Rep. 4, A-15

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their

requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.(16) Each medical school should

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establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards

should consider having members of the public participate in appropriate board activities.(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported. (30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital. (31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems. (32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels. (33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance. (36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education. (37) Our AMA will publicize to medical students,

residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

Modified: CME Rep. 01, I-17Appended: Res. 961, I-18

Transparency of Health Care Provider Profiles in Commercial and Federal Physician Comparison Databases H-405.956
1. Our AMA encourages accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy. 2. Our AMA urges commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s), in accordance with existing AMA policy.
CME Res. 821, I-15

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
Appended: Res. 318, A-19

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AMA Support for Increasing Access to Shadowing Opportunities for Premedical Students 295.179MSS

AMA-MSS encourages state medical societies to create a database of physicians willing to provide shadowing opportunities to undergraduate students.

MSS Res 37, A-14

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 046
(November 2020)

Introduced by: Arjun Kumar, Christian Coletta, Deepa Sridhar, Scott Kivitz, Amee Pansuriya New York Institute of Technology College of Osteopathic Medicine; Jinsol Hyun, Leanna Knight, Jessica Hubert, University of Rochester School of Medicine; Yunghang Chan, Boyi Li, New York Medical College; Naomi Isaac, Touro College of Osteopathic Medicine Middletown; Varsha Venkatakrishna, Divya Seth, Touro College of Osteopathic Medicine Harlem; Samantha Pavlock, Florida State University College of Medicine

Sponsored by: Region 2, Region 4, Region 6

Subject: Didactic Pre-Clinical Education on De-escalation, Violence and Abuse Prevention in the Healthcare Workplace

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Occupational Safety and Health Act of 1970 requires employers to ensure the workplace is free of hazards that could lead to death or serious physical harm[1]; and

Whereas, The Occupational Safety and Health Administration (OSHA) upholds the Occupational Safety and Health Act by providing specific guidelines for employers to develop prevention programs to decrease workplace violence; these guidelines extend to a wide range of healthcare workers, including those in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment centers, pharmacies, community-care centers, and long-term care facilities[1]; and

Whereas, OSHA defines workplace violence as ‘any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site’ with ranges from threats and verbal abuse to physical assaults and even homicide[1]; and

Whereas, To decrease the prevalence of workplace violence, OSHA guidelines recommend that healthcare workers are trained in the ‘universal precautions for violence’ which include discouraging workers from wearing necklaces or chains to prevent strangulation in confrontational situations, discouraging workers from carrying keys or items that could be used as weapons against them, encouraging the use of wearing a head net or cap so hair cannot be grabbed and used to pull or shove them, and advising workers to take additional precautions when working at unconventional hours[1]; and

Whereas, According to World Health Organization, between 8-38% healthcare workers suffer physical violence at some point in their careers[2]; and

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Whereas, health care workers represent one of the most at-risk groups, with rates of serious workplace incidents occurring 4 times more often in the healthcare setting than in private industry[3]; and

Whereas, workplace violence against healthcare workers continues to remain underreported and has been normalized as being "part of the job"[4]; and

Whereas, in 2018 the American College of Emergency Physicians (ACEP) reported that nearly 7 out of 10 emergency physicians believe workplace violence is increasing[5]; and

Whereas, in 2018 the American College of Emergency Physicians (ACEP) reported that 80% of emergency physicians say that violence in the emergency department has harmed patient care[5]; and

Whereas, according to the Bureau of Labor Statistics, psychiatric hospitals have the highest incidence rate of nonfatal intentional injury by other person[6]; and

Whereas, in the psychiatric ward factors such as schizophrenia, young age, alcohol use, drug misuse, history of violence, and hostile-dominant interpersonal styles were found to be the predictors of patient violence[7]; and

Whereas, studies have shown that after an episode of workplace violence, there are increased rate of burnout, job dissatisfaction, and decreased productivity[8]; and

Whereas, according to Dr. Terry Kowalenko MD, chair of the Department of Emergency Medicine at the Medical University of South Carolina College of Medicine, who also studies workplace violence, de-escalation training should be mandatory and involve anyone who interacts with patients, including medical students[9]; and

Whereas, Workplace violence prevention training should include educating medical students on handling challenging patients, preventing or defusing potentially violent situations, de-escalation and self-defense measures with a hands-on component, and progressive behavior control methods including when and how to apply restraints properly and safely if necessary[10]; and

Whereas, current medical school education does not require incorporation of de-escalation, violence, and abuse prevention in the healthcare workplace; therefore

RESOLVED, That our AMA-MSS amend Workplace Violence Prevention H-215.978 to read

H-215.978 – Workplace Violence Prevention

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians and medical students are advised; and (2) encourages physicians and medical students to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's

policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

RESOLVED, That our AMA-MSS encourages medical schools to provide didactic pre-clinical education on de-escalation, violence and abuse prevention in the healthcare workplace.

RESOLVED, That our AMA-MSS encourages the appropriate stakeholders to conduct research on the benefits of de-escalation, violence and abuse prevention trainings to preclinical medical students.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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Workplace Violence Prevention H-215.978
Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; and (2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; **participate in training to prevent and respond to workplace violence threats**; report all incidents of workplace violence; and promote a culture of safety within their workplace.
BOT Rep. 16, A-94; Reaffirmation; I-99; Reaffirmation; I-03; Modified: CSAPH Rep. 1, A-13; Modified: CSAPH Rep. 07, A-16.

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to **provide both didactic and practice-based experiences in public health for residents in all specialties** including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively **encourages the development of innovative models to integrate public health content across undergraduate**, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties
CME Rep. 11, A-09; Reaffirmed: CME Rep. 03, I-18

Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training H-295.868
1. Our AMA recommends that **formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools** and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.
4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.

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5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to **coordinate and encourage provision of disaster preparedness education and training in medical schools** and in graduate and continuing medical education.
7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency
CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
The AMA will continue its **support for the education of medical students** and residents on domestic violence by **advocating that medical schools** and graduate medical education programs **educate students** and resident physicians **to sensitively inquire** about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.
Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16

Clinical Skills Training in Medical Schools D-295.960
Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure **appropriate emphasis of clinical skills training in medical schools**; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January

2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.
Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13

Preventing Violent Acts Against Health Care Providers H-515.957
Our AMA:
(1) encourages the Occupational Safety and Health Administration to develop and enforce a standard addressing workplace violence prevention in health care and social service industries;
(2) encourages Congress to provide additional funding to the National Institute for Occupational Safety and Health to further evaluate programs and policies to prevent violence against health care workers; and
(3) encourages the National Institute for Occupational Safety and Health to adapt the content of their online continuing education course on workplace violence for nurses into a **continuing medical education course for physicians**.
CSAPH Rep. 07, A-16

Identifying and Reporting Child Abuse H-515.960
1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
2. Our AMA supports **development of a comprehensive educational strategy across the continuum** of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the **joint development of didactic programs** designed to foster increased interaction and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.
CSAPH Rep. 2, I-09; Appended: Res. 411, A-18

Violence and Abuse Prevention in the Health Care Workplace H-515.966
Our AMA encourages all health care facilities to: **adopt policies to reduce and prevent all forms of workplace violence and abuse**; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.
Res. 424, I-98; Reaffirmation; I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16

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Violent Acts Against Physicians H-515.982
Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity; (3) will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers; and (4) will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise.
Res. 605, A-92; Reaffirmation; I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13

Preventing Violent Acts Against Health Care Providers D-515.983
Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) **widely disseminate information on effective workplace violence prevention interventions** in the health care setting as well as opportunities for training.
Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, A-16

Elder Mistreatment D-515.985
Our AMA:
1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.
2. **Promotes collaboration** with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in **establishing training in elder mistreatment for all medical students**; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination. […]
CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS
[…] (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and […]
MSS Amended Res 28, A-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Medical Education in Nutrition 150.001MSS
AMA-MSS will ask the AMA to encourage the institution of a core course in nutrition in the basic science curriculum of US medical schools.
AMA Amended Res 82, I-80 Adopted [H-150.993]...;Reaffirmed: MSS Rep B, I-00; Reaffirmed; MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10); Reaffirmed: MSS GC Rep D, I-15

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Incorporation of Adoption into Public School Health Education Curriculum 170.003MSS
the AMA to support the incorporation of information on adoption into public school sex education or family planning curricula
AMA Amended Res 4, I-90 Adopted; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Guidelines for Do-Not-Resuscitate Orders 295.003MSS
AMA-MSS will ask the AMA to enlist the support of the Association of American Medical Colleges in recommending that medical schools, as part of their educational curriculum for medical students, include the ethical, legal, and emotional aspects surrounding do-not-resuscitate orders.
AMA Amended Res 79, I-82 Adopted; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Geriatric Medicine 295.006MSS
AMA-MSS will ask the AMA to reaffirm its position for the incorporation of geriatric medicine into the curriculum of major medical school departments and its position of emphasizing further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels.
AMA Amended Res 137, A-85 Adopted [H-295.981]; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Curriculum in Child Abuse and Neglect 295.007
AMA-MSS will ask the AMA to urge all US medical schools to include in their required curriculums both formal lectures and clinical instruction in the subject of child abuse and neglect.
AMA Sub Res 136, A-85, Adopted [H-515.994]; Reaffirmed: AMA-MSS Digest of Policy Actions/ 84 MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05;Reaffirmed: MSS GC Rep F, I-10;H-515.994 Rescinded: CSAPH Rep. 1, A-13;Reaffirmed: MSS Res 13, A-14; Reaffirmed: MSS GC Rep A, I-19

Teaching Clinical Medical Ethics 295.008
AMA-MSS will ask the AMA to support required medical ethics instruction in medical schools by encouraging medical schools to make medical ethics a part of the required curriculum.
AMA Res 126, A-86, Adopted [H-295.978]; Reaffirmed: MSS Rep E, I-96; Reaffirmed: MSS Rep B, I-01;Reaffirmed: MSS Rep F, I-06; Reaffirmed: MSS GC Rep D, I11; Reaffirmed: MSS GC Report A, I-16

Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence 515.002MSS
AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and support personnel providing legal medical services.
AMA Sub Res 215, I-93 Adopted [H-460.945]; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I- 10; Reaffirmed: MSS GC Rep D, I-15

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Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education 515.015MSS
AMA-MSS will ask the AMA to encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians, by amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care as follows:

H-515.952 – Adverse Childhood Experiences and Trauma-Informed Care […]

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula

MSS Res. 64, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 047
(November 2020)

Introduced by: Bennett Vogt, University of Massachusetts Medical School; Tyler Lang, Tufts University School of Medicine; Jonathan You, Stanford University School of Medicine.

Sponsored by: Region 7

Subject: Supporting measures to ensure safe indoor home temperatures.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The World Health Organization recognizes low indoor home temperatures as a contributor to respiratory and cardiovascular morbidity, and recommends that indoor home temperatures should be high enough to protect against poor health outcomes[1]; and,

Whereas, Vulnerable individuals with lower socioeconomic status have lower indoor home temperatures during cold weather months[2]; and,

Whereas, A literature review of apartment heating and insulation modifications showed fewer mental disorders per resident and a reduction in the degree of hypertension[3]; and,

Whereas, A randomized control trial in New Zealand showed that insulation retrofits in low-income developments reduced the odds of fair or poor self-rated health, poor mental health, and missed work or school days[4]; and,

Whereas, A working paper from the National Bureau of Economic Research illustrated that increased heating price in the U.S. was associated with increased mortality, suggesting an impact on low-income households especially[5]; and,

Whereas, Alternatives to heating when it is unaffordable include burning trash, turning on ovens, or activating space heaters, which are a leading cause of deaths due to residential fires[6,7]; and,

Whereas, The 2019 UN emissions report projects that at the current emissions level the world is likely going to experience a 3 °C temperature rise over the next century[8]; and,

Whereas, Increasing temperatures across the United States are likely to have adverse effects on human health including acute heat stroke and long-term damage to internal organs with special emphasis on vulnerable populations such as children, the elderly, and low-income individuals who cannot afford air conditioning[9]; and,

Whereas, In Rhode Island a study showed that an increase in maximum daily temperature from 75 °F to 85 °F was associated with a 24% increase in heat-related emergency room visits[10]; and,

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Whereas, In South Carolina, temperatures above 35 – 37 °C were associated with a statistically significant increase in emergency room hospitalizations[11]; and,

Whereas, In a survey of Houston residents during the summer of 2011 (n=901), 20% reported heat-related symptoms[12]; and,

Whereas, These studies suggest a particularly strong association with the impact of heat-related illness on individuals with low socioeconomic status[11,12]; and,

Whereas, Low-income households must commit up to 10% or more of their household income to utilities regularly, which places undue economic burden on the households[6,13-15]; and,

Whereas, The US Department of Health and Human Services administers the Low-Income Home Energy Assistance Program (LIHEAP) which provides federal block grants to states to assist in heating, cooling, and weatherization[16,17]; and,

Whereas, The amount of additional state funding and how states choose to use the block grants is highly variable[17]; and,

Whereas, LIHEAP currently addresses only 15% of potentially eligible households despite initially addressing 36% of eligible households when it was founded in 1981[18]; and,

Whereas, In 2018, LIHEAP funding enabled New York State to provide air conditioners to low-income vulnerable populations on a first-come-first-served basis, which could be expanded further to other states as a high-temperature mitigation solution; and,

Whereas, Only twelve states have seasonal termination protection provisions that prevent utility companies from canceling service in the event of delayed payment receipt for temperatures above 95 °F or 103 °F, only 24 states have temperature-based policies for extreme warm or cold temperatures, and many policies require health professional attestation of medical need for termination protection[18]; and,

Whereas, The Children's Sentinel Nutrition Assessment Program demonstrated that LIHEAP enrollment is associated with less evidence of undernutrition, no evidence of increased overweight, and lower odds of an acute hospitalization in children under three in comparable low-income households, suggesting that families are able to transfer savings on utility costs into greater food security and health[19]; and,

Whereas, during the COVID-19 pandemic, job losses are exacerbating energy insecurity and putting lives at risk, especially for low-income and rural residents[6]; and,

Whereas, Our AMA supports housing modifications for vulnerable populations (Support for Housing Modification Policies H-160.890) and efforts to combat the effects of climate change (Global Climate Change and Human Health H-135.938), but no specific policies address the impact of indoor home temperatures on health; therefore be it

RESOLVED That our AMA support environmentally conscious efforts aimed at providing safe indoor temperatures which may include more efficient weatherization, income-based subsidies, and/or seasonal termination protections to mitigate poor health outcomes among at-risk populations.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant.
These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
CSAPH Rep. 3, I-08 Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental

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sustainability in their practices and help physicians to share these concepts with their patients and with their communities. Res. 924, I-16; Reaffirmation: I-19

Support for Housing Modification Policies H-160.890
Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities. Res. 806, I-19

Support for Housing Modification Policies 90.008MSS
AMA-MSS will ask the AMA to support legislation for health insurance coverage of housing modification benefits for: a) the elderly, and b) other populations including but not limited to the disabled, soon to be disabled, and other person(s) with physical and/or mental disability that require these benefits in order to mitigate preventable health conditions. MSS COLA Rep A, A-19; AMA Res. 806, Adopt as Amended [H-160.890]) I-19

Toward Environmental Sustainability 135.012MSS
AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. MSS Amended Rep A, I-07; AMA Res 607, A-08 Referred; Modified: MSS GC Report A, I-16

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States 440.060MSS
AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:

> **Eradicating Homelessness H-160.903**
> Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; <u>(2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3)</u> supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 048
(November 2020)

Introduced by: Sarah Mae Smith, University of California-Irvine School of Medicine; Lawson Traylor, University of South Carolina School of Medicine Greenville; Nikita Sood, Washington University School of Medicine in St Louis; Samantha Pavlock, Florida State University College of Medicine; Danny Luong, Marian University College of Osteopathic Medicine; Jara Crawford, Indiana University School of Medicine; Sanjay Jinka, Northeast Ohio Medical University, Miguel Devonish, Morehouse School of Medicine; Alyson Rich, Penn State University College of Medicine; Megan Quamme, Medical College of Wisconsin

Sponsored by: Region 1, Region 2, Region 4, Region 7, Association of Native American Medical Students

Subject: Support for Vote-by-Mail

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and residents to vote by mail[1]; and

Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept risk or fear of COVID-19 infection as a valid reason[2-4]; and

Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over 198,000[5-6]; and

Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking, with a prevalence of 14% of adults in 2018[7]; obesity, with a prevalence of 42% of adults in 2017-2018[8]; and diabetes with a prevalence of 10% of adults in 2018[9]; and

Whereas, Public health experts continue to warn governments and the public to prepare for future pandemics which may arise similarly to the COVID-19 pandemic[10-12]; and

Whereas, A study of the 2020 Wisconsin primaries found “a statistically and economically significant association between in-person voting and the spread of COVID-19 two to three weeks after the election”[13]; and

Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle closures, limited in-person interactions, and the cancellation of many large public gatherings[14]; and

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Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and longer waiting times in the 2020 primaries[15-17]; and

Whereas, Following widespread adoption of community mitigation measures to target SARS-CoV-2, influenza rates among sentinel countries in the southern hemisphere have been dramatically lower than historical averages during their peak influenza season[18], suggesting the continuance of such measures past the COVID-19 pandemic could contribute to a reduction in the incidence of influenza; and

Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability[19]; and

Whereas, In the 2016 general election, the US Government Accountability Office found that 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in unsafe or insecure conditions for these voters[20]; and

Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse absentee balloting and permanent absentee voting increases voter turnout among citizens with disabilities[21]; and

Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure that likely has increased in the years since given greater life expectancy among immunosuppressed adults due to advancements in medical management and new indications for immunosuppressive treatments[22]; and

Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote share[23]; and

Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately 23.1% of all votes cast in the 2018 general election having been by mail[24]; and

Whereas, Members of the military have voted-by-mail in some form since the Civil War, and citizens living abroad also submit their ballots by mail[25-27]; and

Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately increases overall average turnout rates, in line with previous estimates[23]; and

Whereas, Numerous national and local government officials have expressed opposition to expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection[24,28-32]; and

Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one study finding only 0.0025% of votes being flagged as possible cases of election fraud in the 2016 and 2018 general elections[33]; and

Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel the in-person proceedings of the 2020 Interim Meeting while preserving the voting process through transition to an innovative virtual format[34]; and

Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will continue to be an urgent risk for voters and poll workers in subsequent elections like federal runoff

elections conducted in Georgia and Louisiana and local elections conducted in Spring 2021[35-38]; therefore be it

RESOLVED, That our AMA support measures to reduce crowding at polling locations and facilitate equitable access to voting for all voters, including:
(a) extending polling hours;
(b) increasing the number of polling locations;
(c) extending early voting periods;
(d) mail-in ballot postage that is free or prepaid by the government; and
(e) adequate resourcing of the United States Postal Service and election operational procedures; and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail; and be it further

RESOLVED, That this resolution be immediately forwarded to the Interim 2020 House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Bolstering Public Health Preparedness H-440.892
Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease. Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

Mental Illness and the Right to Vote H-65.971
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness. Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

Medical Student, Resident and Fellow Legislative Awareness H-295.953
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows. Res. 14, A-91, Reaffirmed: Sunset Report, I-01, Appended: Res. 317, A-10, Appended: Res. 307, A-15

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

innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy. Res. 608, A-17

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:
Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph. Res. 8, A-11

270.039MSS Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections
AMA-MSS will ask the AMA to study the rate of voter turnout of physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community. (MSS Res. 14, I-19)

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

310.021MSS Promoting Resident Involvement in Organized Medicine
AMA-MSS encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and organized medicine conferences. (MSS Sub Res 13, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

565.005MSS Transforming for Tomorrow: Advocacy Framework
AMA-MSS will: (1) work to establish an additional legislative internship or clerkship opportunity for a medical student in the AMA’s Washington, D.C. Office; and (2) continue to explore potential partnerships with other branches of the AMA to enrich our student advocacy opportunities. (MSS GC Rep C, I-14)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 049
(November 2020)

Introduced by: Rajadhar Reddy, Andrea Grimbergen, Baylor College of Medicine; Alyssa Francis, Chandni Vashee, Texas Tech University Health Sciences Center El Paso Foster School of Medicine; Neya Sterling, Northeast Ohio Medical University; Sarah Luke, University of Texas Medical Branch at Galveston; Ida Vaziri, University of Texas Health Science Center San Antonio Long School of Medicine

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6

Subject: Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, From 2008 to 2017 across 14 states, the US Centers for Disease Control and Prevention (CDC) reported that across 14 states from 2008 to 2017, 23.6% of pregnancy-related deaths take place between 42 days and 12 months postpartum[1]; and

Whereas, From 2008 to 2017 across 14 states, the CDC reported that 65% of pregnancy-related deaths occurring before 12 months postpartum were preventable, with causes including cardiovascular conditions, hemorrhage, infection, embolism, preeclampsia and eclampsia, and mental illness (including suicide and overdose)[1]; and

Whereas, The 2010 Affordable Care Act (ACA) expanded Medicaid and provides federal subsidies to purchase private health insurance plans depending on an individual's income, but 10.8 million women in the US remain uninsured[2]; and

Whereas, More than 1 million women fall into the Medicaid coverage gap, in which they remain uninsured because their income is too high to qualify for Medicaid, but too low to qualify for federal subsidies to purchase private health insurance plans on ACA marketplaces[2]; and

Whereas, In most states, some patients who are usually ineligible for Medicaid can temporarily qualify if they become pregnant, but in many states, this coverage expires after 60 days postpartum, and undocumented immigrants are still often barred from qualifying at all[3]; and

Whereas, Undocumented immigrants are often uninsured and in many states are ineligible for public assistance for healthcare coverage, such as Medicaid, the Children's Health Insurance Program (CHIP), and federal subsidies for ACA marketplace private health insurance plans[2,4]; and

Whereas, Even if they become pregnant, undocumented immigrants are still often barred from qualifying for public assistance for healthcare coverage[2,4]; and

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Whereas, Based on the recommendations of many state maternal mortality review committees, the American College of Obstetricians and Gynecologists (ACOG) supports the extension of Medicaid coverage from 60 days (the limit in many states) to 12 months postpartum to improve pregnancy-associated mortality and morbidity outcomes[5]; and

Whereas, The AMA's existing Policy D-290.974, "Extending Medicaid Coverage for One Year Postpartum," states that the AMA "will work with relevant stakeholders to support the extension of Medicaid coverage to 12 months postpartum"[6]; and

Whereas, Existing AMA policy does not adequately address the lack of pregnancy-associate healthcare coverage for patients ineligible for Medicaid due to state restrictions or immigration status[2,3]; and

Whereas, 17 states offer pregnancy-associated healthcare coverage to patients ineligible for Medicaid under CHIP, but vary in how long coverage may last, with Texas offering only two postpartum visits for the mother[7,8]; and

Whereas, In 2016, the US Centers for Medicare & Medicaid Services (CMS)' Center for Medicaid & CHIP Services stated that "state Medicaid agencies may cover maternal depression screening as part of a well-child visit," which created precedent for some parental healthcare coverage under both Children's Medicaid and CHIP, and provided uninsured parents ineligible for Medicaid a path to receiving some care[9]; and

Whereas, As of 2018, screening for peripartum depression during the pediatric well-child visit is a covered benefit under state Children's Medicaid programs in twenty-five states[10]; and

Whereas, Screening for peripartum depression is a cost-effective healthcare intervention, with one study showing upwards of $13,000 gained per Quality Adjusted Life Year (QALY) compared to no intervention[11]; and

Whereas, If extension of Medicaid coverage to 12 months postpartum is important for public health, this benefit should also be extended to uninsured patients ineligible for Medicaid, including those who fall into the Medicaid coverage gap or are undocumented[1,2]; therefore be it

RESOLVED, That, to expand coverage of pregnancy-associated healthcare for more uninsured patients and further reduce pregnancy-associated morbidity and mortality, AMA Policy H-290.974, "Extending Medicaid Coverage for One Year Postpartum," be amended by insertion as follows:

> **Extending Medicaid Coverage for One Year Postpartum D-290.974**
>
> 1) Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.
> 2) Our AMA will work with relevant stakeholders to support coverage of pregnancy-associated healthcare until at least 12 months postpartum for uninsured patients ineligible for Medicaid, including, but not limited to, coverage under their child's health insurance plan through Children's Medicaid, the Children's Health Insurance Program (CHIP), or private insurers.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

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Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 050
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville

Sponsored by: Region 4, Asian Pacific American Medical Student Association

Subject: Advocating for Legal Permanent Resident Status, a Pathway to Citizenship, and Current Protections for Individuals with Deferred Action for Childhood Arrival (DACA) Status

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

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

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

Whereas, The total number of individuals with DACA status as of March 2020 is 643,560[2]; and

Whereas, 200 of the estimated 27,000 health care workers and support staff who depend on DACA for work authorization are medical students, residents, and physicians[3,4]; and

Whereas, A focus group of 61 DACA-eligible Latinos that were asked about their mental health and wellbeing reported that the DACA program helped them be a part of American society easier by relieving stress associated with obtaining a job, applying to college, getting a license, etc.[5]; and

Whereas, These individuals also noted that DACA improved their self-image and helped improve their self-confidence[5]; and

Whereas, When asked about the temporary status that DACA confers, these individuals reported an immense amount of stress knowing that the program could be taken away in the future[5]; and

Whereas, On September 5, 2017, the Trump administration announced that it would be taking immediate action to end the DACA program and would no longer be accepting new applications[6]; and

Whereas, The rescission of the DACA program created fear and uncertainty for families who rely on this program, which can lead to decreased utilization of health care, increased fear of deportation, and an overall worsening of self-reported mental health[7]; and

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Whereas, Constant fear and uncertainty surrounding the fate of the DACA program can lead to toxic stress, which has been linked to negative impacts on long-term physical, mental, and emotional health[7-21]; and

Whereas, Soon after the announcement of this decision by the administration, various lawsuits were filed against this ruling that questioned the legality of how the program was being ended, both of which were taken up by the Supreme Court on June 28, 2019[6]; and

Whereas, The Supreme Court ruled on June 18, 2020 that the DACA program will be allowed to continue as-is for now as the Department of Homeland Security (DHS) did not follow proper protocol when attempting to end the program[6]; and

Whereas, After the Supreme Court ruling was announced, the acting secretary for the DHS, Chad Wolf, released a memorandum on July 28, 2020, that stated that pending a full review of the DACA program, new applications would not be accepted, requests for advance parole would not be heard, and renewals would be shortened[22,23]; and

Whereas, Before the Supreme Court had agreed to hear the case, there were attempts within both the House of Representatives and Senate to establish a replacement for the DACA program that would lead to either legal permanent resident status and/or citizenship[24,25,26]; and

Whereas, These pieces of legislation were referred to as the American Dream and Promise Act of 2019 and Dream Act of 2019 respectively[24-26]; and

Whereas, Despite successfully being passed in the House of Representatives, the bill has never been passed within the Senate and has been in the Senate Judiciary Committee since that time[24-26]; and

Whereas, The AMA has supported previous legislation to either preserve DACA status or create a replacement program, along with filing an amicus brief in November 2019 that supports the Supreme Court upholding the legality of the DACA program[4,5,27]; and

Whereas, Our AMA supports studying how DACA recipients can be incorporated into the physician profession (AMA Policy D-350.986); therefore, be it

RESOLVED, That our AMA advocates for the establishment of a pathway to legal permanent resident status and/or citizenship status for those individuals who are currently eligible for or who have Deferred Action for Childhood Arrivals (DACA) status; and be it further

RESOLVED, That our AMA supports legislation, rather than an executive order or other means, to accomplish these actions and opposes extraneous barriers that would cause undue stress as a requirement for these individuals to obtain either legal permanent resident status or citizenship status.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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

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

2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
Res. 305, A-15; Appended: Late Res. 1001, I-16; Reaffirmation: A-19

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students

from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

Underrepresented Student Access to US Medical Schools H-350.960

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Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15

Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages 295.185MSS
AMA-MSS will ask that the AMA study the issue of Deferred Action for Childhood Arrivals (DACA)-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
(MSS Late Res 4, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Medical Licenses for Individuals with DACA Status 275.015MSS
AMA-MSS will ask the AMA to 1) support the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses and 2) encourage state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states.
(MSS Res. 02, I-19)

Continued Support for Diversity in Medical Education 350.011MSS
AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.
(MSS Res 3, A-03) (AMA Res 325, A-03 Adopted [D-295.963]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS Res 27, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 051
(November 2020)

Introduced by: David Davila, Shreya Ranjan, Tufts University School of Medicine

Sponsored by: N/A

Subject: Employment of Patients with Psychiatric Illness

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Mental illness is a leading cause of work impairment[1]; and

Whereas, People with mental illness are at a high lifetime risk for being excluded from the work force and living alone[2]; and

Whereas, Unemployed people with mental illness are less able to seek adequate health care than those who are employed[3]; and

Whereas, Evidence shows that patients with psychiatric illness have a higher quality of life and fewer hospitalizations when given supported employment than when not[4]; and

Whereas, Employment is associated with a higher health related quality of life in patients with schizophrenia[5]; and

Whereas, Adults with serious mental illness, defined as disorders that result in functional impairment that interfere with one or more major life activities[6], have a desire to engage in age appropriate employment, despite the barriers to education and employment presented by illness[7-9]; and

Whereas, Both a small number of working hours and meaningful full-time work demonstrated a positive impact on mental health and well-being[10,11]; and

Whereas, The relationship between severity of borderline personality disorder symptoms and poor physical health is diminished in patients who are employed[12]; and

Whereas, Re-employment programs have a positive effect on the quality of life of people with severe mental illness[13]; and

Whereas, Evidence suggests that advocating for competitive work as a treatment target for psychiatric illness is on par with symptom management and self-care skills[13]; and

Whereas, Individual Placement and Support (IPS) programs help individuals with mental illness find and succeed in competitive employment by combining assertive community treatment and supported employment[14]; and

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Whereas, Studies show that IPS services help people with mental illness find jobs more quickly and keep them longer[3,15,16]; and

Whereas, Supported employment programs are being utilized in 38 of the 50 states[17]; and

Whereas, IPS is shown to be more effective than traditional vocational rehabilitation[3,18]; and

Whereas, A randomized controlled trial across six European countries demonstrated that IPS provided better outcomes at a lower cost than alternative vocational services[19]; and

Whereas, A meta-analysis of 30 randomized controlled trials, including ones that specifically studied U.S. IPS programs, showed that IPS had higher rates of competitive employment and shorter time to find first employment[20]; and

Whereas, Supported employment services, such as IPS, are not currently reimbursed by Medicaid[9], as opposed to "vocational rehabilitation" services[21]; and

Whereas, Studies show that 70% of people with serious mental illness want competitive jobs but only 2% of such individuals receive IPS[14]; therefore be it

RESOLVED, That our AMA recognizes the role that employment has in improving the health and quality of life for patients with psychiatric disorders; and be it further

RESOLVED, That our AMA advocates for the employment of patients with psychiatric illness through measures such as the development of Individual Placement and Support (IPS) programs.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general

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medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

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

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

4. Our AMA recognizes the impact of violence and social determinants on women's mental health. Res 502, I-96; Reaffirmed A-19

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. BOT Rep. LL, A-86; Reaffirmed BOT Rep. 16, A-19

Statement of Principles on Mental Health H-345.999

(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.

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(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.

(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.

(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
A-62, Modified CSAPH Rep. 01, A-19

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 052
(November 2020)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Amier Haidar, McGovern Medical School; Joey Whelihan, UF College of Medicine; Arjun Kumar, NYIT-COM; Jooeun Jeong, McGovern Medical School; Imaima Casubhoy, University of Missouri Kansas City School of Medicine; Stephanie Wolff, Northeast Ohio Medical University; Natasha McGlaun, University of Nevada Reno School of Medicine; Rachel Anderson, Chicago Medical School; Alexandra Reed, Chicago Medical School; Reilly Bealer, Elson S Floyd College of Medicine; Nikita Sood, Washington University in St Louis School of Medicine; Anne Reisch, Kathryn Stevens, Sarah Gans, University of Connecticut School of Medicine; May Chammaa, Wayne State School of Medicine

Sponsored by: Region 1, Region 3, Region 5, Region 7

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;[1]

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;[2,3] and

Whereas, comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;[4] and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;[5] and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;[5–7] and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;[3] and

Whereas, several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency[8]; and

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Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;[9] and

Whereas, current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;[9] and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics.2 Among Millennials surveyed in 2015, only 12 percent said their sex education classes covered same-sex relationships;[9,10] and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);[11] and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;[3] and

Whereas, in 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;[12] and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;[2,13] and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;[14] and

Whereas, Since 2000, estimated medical costs of $6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;[15] and

Whereas, 40 states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;[11] and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;[16,17] and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;[18] and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;[19–21] and

Whereas, the US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and

no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births[22]; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;[23–25] and

Whereas, comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;[23,26–28] and

Whereas, the federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including PREP, a state-grant program from the federal government that funds comprehensive sex education;[29,30] and

Whereas, As of 2017, forty-one PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;[29] and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;[30] and

Whereas, the American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine's (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;[31–33] and

Whereas, the AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our AMA amend H-170.968 by addition and deletion as follows:

> **Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968**
>
> (1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;
> (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for

delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

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

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

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

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

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

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

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to conduct research an develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Click here to paste relevant AMA and AMA-MSS policy in their entirety. First list all relevant AMA policies, then list all relevant AMA-MSS policies. Always access the most recent version of AMA PolicyFinder and MSS Digest of Actions when referencing existing policy. Sample formatting is shown below.

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

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability

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programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994

The AMA urges television broadcasters, producers, and sponsors to encourage **education** about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

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(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

Comprehensive Health Education H-170.977

(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at

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developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

a) Supports development and implementation of HIV/AIDS **health education** programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific **education** programs and materials to inform minorities of risk behaviors associated with HIV infection.

b) Our AMA urges the communications industry, government officials, and the **health** care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;

c) Encourages **education** of patients and the public about the limited risks of iatrogenic HIV transmission. Such **education** should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and **health** care worker **education** as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;

d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;

e) Encourages religious organizations and social service organizations to implement HIV/AIDS **education** programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

a) Endorses the **education** of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive **health education** in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public **health** officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line **health** workers (specifically including those in addiction treatment and community **health** centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 053
(November 2020)

Introduced by: Swetha Maddipudi, UT Health San Antonio Long School of Medicine; Rajadhar Reddy, Baylor College of Medicine; Natasha Topolski, UTHealth McGovern Medical School; Kishan Pandya, Northeast Ohio Medical University

Sponsored by: Region 2, Region 3, Region 4, Region 5

Subject: Addressing Adverse Effects of Active Shooter Drills on Children's Health

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Active shooter drills are an updated version of lockdown drills that are employed by school systems to prepare students and educators for a possible active shooting scenario [1,2]; and

Whereas, Following the Columbine shooting and subsequent mass shootings, schools began to face an added responsibility to prevent school shootings and many shifted to implementing active-shooter drills to signal their commitment to risk management to parents and communities [2–4]; and

Whereas, Ninety five percent of schools conducted drills for emergency procedures including lockdowns, evacuations, and shelter-in-place procedures in 2015-2016 [5]; and

Whereas, At least 40 states require school-based drills for active shooter scenarios but state laws leave the composition of the drill open to interpretation by school administrators [1]; and

Whereas, Active shooter preparation drills have increased in number following a change in stance by the Department of Education in 2012 which called for “options-based” approaches for its active-shooter response recommendations [6]; and

Whereas, An “options-based” approach encourages schools to tailor their prevention activities to both educators and students and provides them with training to respond appropriately in the event of an active shooter scenario [6]; and

Whereas, Limited research exists that demonstrates a significant difference between lockdown drills and multioption approaches in preparation for an active shooter event [4]; and

Whereas, The advent of this new approach has resulted in a new industry driven by providing a variety of techniques that school systems can employ during a practice drill, including playing 911 recordings from prior shootings, using rubber bullets, masked “shooters”, and fake blood [6,7]; and

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Whereas, Despite the lack of research on the efficacy of active shooter drills, school districts continue to pay tens of thousands of dollars to for-profit third-party companies allowing them to enter the school environment and facilitate the active shooter drills [1,4,8]; and

Whereas, Physicians and national organizations, including the National Child Traumatic Stress Network, National Association of School Psychologists, and American Federation of Teachers, express concern over the harmful effects that active shooter drills may have on the health and wellbeing of children [3,6,9]; and

Whereas, the National Association of School Psychologists and the National Association of School Resource Officers acknowledge that drills have the power to empower and save lives, but can cause harm to participants without proper caution [10]; and

Whereas, a study conducted on college students found that, though they felt more prepared after watching a school shooting training video, they were also more afraid that one would occur [11] ; and

Whereas, Schools often do not follow the guidelines for lockdown drills recommended by the National Association of School Psychologists and the National Association of School Resource Officers such as inclusion of mental healthcare professionals during and after drills [12]; and

Whereas, In a study of student perceptions pre- and post formal active shooter training including lockdown drills, found that despite students feeling more prepared for an emergency lockdown situation, perceptions of safety in school were significantly decreased [2]; and

Whereas, The National Association of School Psychologists and the National Association of School Resource Officers admit that, while research supports the effectiveness of lockdown drills, research is still needed on the effectiveness of armed assailant drills [10]; therefore be it

RESOLVED, That our AMA support that elementary and secondary schools only conduct active shooter drills in a trauma-informed manner that

a. is cognizant of children's physical and mental wellness,
b. considers prior experiences that might affect children's response to a simulation,
c. avoids creating additional traumatic experiences for children, and
d. provides support for students who may be adversely affected; and be it further

RESOLVED, That our AMA work with relevant stakeholders, such as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatrists, the National Association of School Psychologists, and the National Child Traumatic Stress Network, to raise awareness of ways to conduct active shooter drills that are safe for children and age-appropriate; and be it further

RESOLVED, That our AMA encourage physicians with appropriate expertise to become involved in their local school systems to guide the use of active shooter drills in firearm injury prevention efforts.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Prevention of Firearm Accidents in Children H-145.990
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.
Res 165, I-89; Appended BOT Rep. 11, I-18

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law. Res 204, I-98; Reaffirmed: CSAPH Rep. 01, A-19

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Res 221, A-13; Reaffirmed: I-18

Preventing Fire-Arm Related Injury and Morbidity in Youth 145.014MSS

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AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14)(Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 054
(November 2020)

Introduced by: Tariq Issa, Northwestern University Feinberg School of Medicine; Tsola Efejuku, University of Texas Medical Branch; Neha Siddiqui, Carle Illinois College of Medicine; Subhash Gutti, George Washington School of Medicine and Health Sciences; Ananya Sharma, Vanderbilt University School of Medicine.

Sponsored by: Region 5

Subject: Supporting the Study of Reparations as a means to Reduce Racial Inequalities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community,[1–4] including disproportionate rates of incarceration,[5–7] residential segregation,[8] and unfair labor and employment policies; and,

Whereas, Toxic stresses of racism[9], incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior[10], disease, and early death in minority children[11,12]; and,

Whereas, The racial wealth gap in the United States has increased dramatically, as households with black children hold just one cent for every dollar held by households with non-Hispanic white children as of 2016[13,14]; and,

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes[15,16]; and,

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities,[17,18] which are correlated with positive health outcomes,[19,20] for the African American community; and,

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations[14,21]; and,

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities[21]; and,

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including $5.5 million in direct compensation,

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free college education to survivors, a formal apology from the city, and education on police torture in public schools[22]; and,

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities[14,23], and,

Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989[21]; and,

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes[23–25]; and,

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over $60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past[26,27]; and,

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation[28-30]; and,

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population[14,30,31]; and,

Whereas, The black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly black medical schools after the 1910 publication of the Flexner Report[31]; and,

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships[32,33]; and,

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders[33]; therefore be it,

RESOLVED, Our AMA will study, in partnership with the Center for Health Equity, how potential mechanisms of national economic reparations may impact health inequities associated with institutionalized, systematic racism; and be it further

RESOLVED, Our AMA will specifically also study, in partnership with the Center for Health Inequity, how a policy of reparations might be adopted by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field; and be it further

RESOLVED, Our AMA will report the results of the aforementioned study to the Board of Trustees at I21, or A21, depending on if this will be an immediate forward.

Fiscal Note: TBD

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Date Received: 08/27/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on **minority** access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the

Office of **Minority** Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. **minority** Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and **Minority** Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

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(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Elimination of Health Care Disparities Resulting from Insurance Status 65.016MSS
AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in AMA-MSS Digest of Policy Actions/ 18 different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations. (MSS Sub Res 29, A-11) (Reaffirmed: MSS GC Report A, I-16)

Racism as a Public Health Threat 350.025MSS
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies. (MSS Res. 30, I-19)

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

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data 440.064MSS
AMA-MSS will ask the AMA to (1) oppose policies that enable racial housing segregation and (2) advocate for continued federal funding of publicly accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (MSS Res 12, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 055
(November 2020)

Introduced by: Brandon Francis, Joseph Baker, Jonathan Wheeler, Megan Chiu, Indiana University School of Medicine

Sponsored by: N/A

Subject: Reducing Complexity in the Public Service Loan Forgiveness Program

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The number of student borrowers in the United States totals 44.7 million individuals with total indebtedness exceeding $1.5 trillion[1]; and

Whereas, Nearly three-fourths of medical students have financed their education with the use of loans [2-4]; and

Whereas, Median student debt upon graduation from medical school totals $200,000, and the total repayment over a physician's career can total from $365,000 to $440,000 depending on repayment plan[3-4]; and

Whereas, If the increasing trend of median student debt upon graduation from $100,000-$135,000 in 2003 to $200,000 in 2012 continues, then resident physicians could face loan payments comprising up to 50% of their monthly earnings[5-7]; and

Whereas, The majority of surgical residents believe that their loan debt is a significant financial burden and that high debt levels influence their "salary goals, perceptions of financial security, career choices, and practice location"[5]; and

Whereas, "High medical school debt has been associated with several adverse outcomes including decreased quality of life, increased stress, lower test scores, and burnout"[5,8]; and

Whereas, There are several repayment options for students, including standard repayment programs, income-based repayment programs, and public student loan forgiveness[9-10]; and

Whereas, The Public Service Loan Forgiveness (PSLF) Program was established under the *College Cost Reduction and Access Act of 2007* in an attempt to reduce federal student loan debt burden for indebted professionals working in the public sector[11]; and

Whereas, The Federal Student Aid (FSA) Office of the United States Department of Education introduced the Employment Certification Form (ECF) in 2012 to try and assist borrowers in assuring that their employment qualifies for the PSLF program, 31% of ECFs received were deemed ineligible[12-13]; and

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Whereas, The FSA began accepting applications in the Fall of 2017 for individuals seeking to be beneficiaries of this program with 187,053 PSLF applications received and processed through May 2020[13]; and

Whereas, The overwhelming majority of these applications, 183,356 or 98.02%, were deemed ineligible due to ineligible qualifying payments (57%), missing information (24%), or no eligible loans (14%)[13]; and

Whereas, The stringent requirements for qualifying payments have disqualified over 104,000 applications for forgiveness and include that every single one of the 120 payments be under a qualifying repayment plan, be for the full amount as shown on the bill, be no later than 15 days from the due date, be made while employed full-time by a qualifying employer, and be made only during periods when you are required to make a payment[13]; and

Whereas, Missing information on PSLF applications has disqualified over 44,000 individuals from forgiveness with missing information ranging from incorrect employer address on the ECF to failure to recertify repayment plans yearly during the entirety of repayment[13-14]; and

Whereas, Over 25,000 applications were denied due to ineligible loans forcing them to consolidate into a qualifying loan and restart their 120 qualifying payments if they chose to participate in PSLF[13]; and

Whereas, The United States Department of Education sought to address these issues in part by expanding eligibility and reconsideration for loan forgiveness via the Temporary Expanded PSLF (TEPSLF) made possible by a $350-million appropriation through the *Consolidated Appropriations Act of 2018*[15-16]; and

Whereas, Under the TEPSLF program, 93.8% of applicants for forgiveness have been denied with the total amount of discharged funds to approved applicants thus far comprising only 16.1% of the total appropriation by Congress[13]; and

Whereas, AMA policy H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt advocates for increased medical student and physician benefits in PSLF[17], it fails to recognize the TEPSLF and does not acknowledge nor attempt to resolve the bureaucratic complexities that make properly accessing these benefits feasible; therefore be it

RESOLVED, Resolved, That our AMA amend H-305.925 by insertion and deletion as follows:

> **H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt**
>
> The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
>
> 1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality

of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

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

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15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for

PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap

medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

Reduction in Student Loan Interest Rates D-305.984

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1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.
Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16

Fixing the VA Physician Shortage with Physicians D-510.990
1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.
Res. 1010, A-16; Appended: Res. 954, I-18; Appended: CME Rep. 6, I-19

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at

least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

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H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.
CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18

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).

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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,

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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.
CME Rep. 04, I-18

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

1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students.
2. That the AMA-MSS will ask the AMA to oppose the reduction and support that expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness.
3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including, but not limited to, the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency.

(MSS GC Rep A, I-17)

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

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

sample letter of support for this cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.
(MSS GC Rep A, I-17)

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 056
(November 2020)

Introduced by: Samantha Pavlock, Florida State University College of Medicine; Molly Benoit, University of Miami Miller School of Medicine; Sahar Panjwani, University of Texas Rio Grande Valley School of Medicine; Mata Alexi Adams, Mercer University School of Medicine; Arvinth Sethuraman, Rutgers New Jersey Medical School; Leely Rezvani, Tulane University School of Medicine; Amrit Vasdev, University of Minnesota-Twin Cities Medical School; Karisma Chhabria, Northwestern University Feinberg School of Medicine; Katherine Marciniec, Des Moines University College of Osteopathic Medicine; Silpa Raju, University of Illinois College of Medicine.

Sponsored by: Region 2, Region 3, Region 4, Region 6

Subject: Increasing regulations of natural cosmetic products

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, An increasing number of cosmetic products have package labeling that claim the product is “natural” or made with “naturally derived” ingredients[1]; and

Whereas, Consumers often perceive products labeled as “natural” or “naturally derived” as being safer than traditional products[2]; and

Whereas, Some cosmetic products labeled as “natural” or “naturally derived” contain high concentrations of botanical extracts that are prominent causes of irritant and allergic contact dermatitis and photosensitization[3-8]; and

Whereas, A recent report found that 40-50% of women have actively sought natural or organic ingredients in their facial skincare products over the last two years[9]; and

Whereas, The United States Department of Agriculture (USDA) regulates the use of the term “organic” as it applies to agricultural products, and cosmetic products can be eligible for organic certification if it contains or is made up of agricultural ingredients and can meet the USDA/National Organic Program standards[10-11]; and

Whereas, Certification of a cosmetic product as “organic” by the USDA refers solely to the production, handling, processing, and labeling of agricultural ingredients, not to ingredient safety[12]; and

Whereas, The USDA does not have authority over the production and labeling of cosmetic products that are not made of agricultural ingredients[13]; and

Whereas, The Food and Drug administration (FDA) has regulatory authority over cosmetic products not certified as “organic” by the USDA[14-15];

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Whereas, The FDA has regulatory authority to take action against companies found in violation of the misbranding clause of the Food, Drug, and Cosmetic Act (FD&C Act) which states "A cosmetic shall be deemed to be misbranded -- (a) If it's labeling is false or misleading in any particular[16-17]."; and

Whereas, This authority gives the FDA the ability to issue public notices, pursue criminal prosecution of manufacturers, file federal restraining orders against the distribution of certain cosmetics, and seize the misbranded product[18-20]; and

Whereas, There is no standard definition of the terms "natural" or "naturally derived" in regard to cosmetic products under existing FDA regulation; and

Whereas, A standard definition of "natural" and "naturally derived" would allow the FDA to enforce the misbranding clause on a cosmetic product if it uses those terms but does not meet the regulatory definition; and

Whereas, Cosmetic products are neither subject to rigorous safety standards nor pre-approval from the FDA prior to entering the market, as is the case for drugs and medical devices[21]; and

Whereas, The Natural Cosmetics Act (H.R. 5107) was introduced in Congress in 2019 and would set standards for use of the terms "natural" and "naturally derived" in cosmetics, regulate their use on packaging or product labels, and consider a mislabeled cosmetic to be misbranded under FDA regulations[22]; and

Whereas, Multiple current AMA policies including but not limited to H-320.953, H-475.992, H-385.923, H-160.943, H-440.880, and H-210.994 support, adopt, or delineate standardized definitions of terms within and across sectors; and

Whereas, Existing AMA policy, H-440.855, supports the creation of a cosmetic ingredient registry and supports expansion of FDA authority to recall cosmetics deemed harmful; therefore be it

RESOLVED, That our AMA support the creation of a standard definition of "natural' or "naturally derived" as it pertains to the labeling of cosmetic products; and be it further

RESOLVED, That our AMA support the expansion of the FDA's regulatory authority to recall misbranded cosmetics by amending National Cosmetics Registry and Regulation H-440.855,

National Cosmetics Registry and Regulation - H-440.855

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it dee~~n~~ms to be harmful~~.~~ or misbranded.

~~2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.~~

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Fiscal Note: TBD

Date Received: 08/27/2020

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10. 7 CFR §205
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20. 21 CFR §7.42(b)(2)
21. 21 CFR §1 to 1499
22. Natural Cosmetics Act, H.R. 5107, 116th Congress (2019)

RELEVANT AMA AND AMA-MSS POLICY

Reducing Lead Poisoning H-60.924

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, [..] and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions. CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17.

Advertising for Herbal Supplements H-150.946

It is AMA policy that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products. Sub. Res. 504, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmation: A-19.

Dietary Supplements and Herbal Remedies H-150.954

2. Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling

4. Our AMA supports that the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease."

5. Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies. Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19.

Definition of "Principal Care" H-160.943

The AMA defines "principal care" as follows: Principal care is ongoing preventive, diagnostic, curative, counseling, or rehabilitative care, provided or coordinated by a physician, that is focused on a specific organ system or disease/condition. Principal care may be provided concurrently with or apart from primary care. The AMA supports Principal Care by taking steps to maintain access to quality Principal Care physicians who by their training, continuing education, experience and peer review have the expertise and knowledge to deliver contemporary and effective Principal Care in the management of acute or chronic diseases or conditions. CMS Rep. 3, A-96; Sub. Res. 726, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17.

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Home Health Care H-210.994
Our AMA (3) supports modifications in Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries. BOT Rep. EE, A-87; Reaffirmed by Res. 122, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed by Res. 129, A-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18.

Definitions of “Screening” and “Medical Necessity” H-320.953

1. Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
3. Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
4. Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
5. Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
6. Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness. CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision, Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06; Reaffirmed: CMS Rep. 01, A-16.

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923

1. Our AMA adopts as policy the following definitions: (a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee); (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans. Res. 109. A-07; Appended: Res. 107, A-13.

National Cosmetics Registry and Regulation H-440.855
Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful. BOT Action in response to referred for decision Res. 907, I-09.

Definition of Health H-440.880

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The AMA officially adopts the following definition of health: "Health is a state of physical and mental well-being." CLRPD Rep., A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16.

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992
(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13.

60.020MSS Reduction of Online Bullying
AMA-MSS will ask the AMA to urge social networking platforms to adopt Terms of Service that define and prohibit cyber-bullying and cyber-hate. MSS Res 23, A11; AMA Res 401, A-12 Adopted as Amended [H-515.959]; Reaffirmed: MSS GC Report A, I-16.

150.027MSS Harms and Benefits of Vitamin and Mineral Supplements
AMA-MSS (1) advocates for increased education and awareness regarding the harms and benefits of vitamin and mineral supplements; and (2) supports the study of vitamin and mineral supplement use in primary prevention of chronic disease. MSS Res 38, A-14; Reaffirmed: MSS GC Rep A, I-19.

270.021MSS National Cosmetics Registry and Regulation
AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all cosmetics and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall cosmetic products determined to be harmful based on the FDA's product recall classifications. MSS Amended Res 11, A-09; Reaffirmed: MSS GC Rep A, I-14; Reaffirmed: MSS GC Rep A, I-19.

420.014MSS Classification and Surveillance of Maternal Mortality:
AMA-MSS will ask the AMA to (1) advocate for an annual release of the national maternal mortality rate in the United States and (2) collaborate with relevant stakeholders to advocate for a reliable, accurate, and standardized definition of maternal mortality that will be implemented across states for tracking data on maternal mortality. MSS Res. 44, I-19

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

505.002MSS Banning or Restricting Smoking in Public Places

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AMA-MSS will ask the AMA to: (2) define "public places" AMA Res 86, I-79 Referred; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15.

525.009MSS Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products

AMA-MSS (1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. MSS Res 27, I-17.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 057
(November 2020)

Introduced by: Gabriel Colón, Paola Caldas, Universidad Central del Caribe School of Medicine Bayamón, PR

Sponsored by: Region 4

Subject: Educate Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, There are four allopathic medical schools in Puerto Rico accredited by the Liaison Committee on Medical Education (LCME) and the Middle States Commission on Higher Education (MSCHE) and members of the Association of American Medical Colleges (AAMC); and

Whereas, Most medical students from Puerto Rican schools are United States citizens and are evaluated by the same standards and examinations administered by the United States Medical Licensing Examination (USMLE) and National Board of Medical Examiners (NBME) as other medical students in the United States[1]; and

Whereas, Based on total medical school enrollment during the 2019-2020 academic year, Puerto Rico ranked 22nd out of 46 states with medical schools with 1,494 enrolled medical students[2,3]; and

Whereas, Just like all other U.S. medical graduates, students from Puerto Rican schools utilize the Visiting Student Learning Opportunities (VSLO/VSAS) portal, the Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) to apply for clinical rotations and residency programs in the continental U.S.; and

Whereas, Medical students attending Puerto Rican medical schools have historically faced many hurdles in their away rotations and residency application process as they are commonly misperceived as International Medical Graduate (IMG) students by other medical students, physicians, and healthcare professionals from the continental US[4] ; and

Whereas, A study in progress shows that recently graduated physicians from Puerto Rican medical schools have reported that during the process of away rotations and residency interviews, they had to explain their citizenship, the accreditation status of Puerto Rican medical schools, the board exams taken, clarify about not being an IMG and their application being denied due to misinformation regarding these topics[5]; and

Whereas, The American Medical Association (AMA) has strong policy supporting parity in access to away rotations for D.O. students, (D-295.309) and policy supporting access to IMGs by abolishing discrimination in licensure (H-255.966**)**, protecting IMGs from unfair discrimination (H-255.978, 255.003MSS), and opposing discrimination in residency selection based on IMG status

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(D-255.982), but notably no policy in support of Puerto Rican medical school students who face similar barriers to IMGs despite being classified as U.S. graduates; and

Whereas, The AMA is interested in evaluating students based on merit (H-255.988, H-255.983) and eliminating discrimination (H-310.919), but lacks policy addressing the importance in merit-based evaluation of medical students from Puerto Rican medical schools; therefore be it

RESOLVED, That our AMA will issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), American Association of Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders to ensure that schools participating in the Visiting Student Learning Opportunities (VSLO/VSAS), Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) systems understand the accreditation of Puerto Rican medical schools and the citizenship of their medical students; and be it further

RESOLVED, That our AMA will support policies that ensure equity and parity in the educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools by ensuring they are judged based on their individual qualifications, skills, and character.

Fiscal Note: TBD

Date Received: 09/20/2020

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5. Caldas P, Colon G, Irizarry J. Cross-sectional study of the experiences graduates from Puerto Rican Medical Schools had during their away elective rotations and residency application process in mainland US programs as fourth year students. In preparation

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Fiscal Note: TBD

Data Received: XX/XX/20

RELEVANT AMA AND AMA-MSS POLICY

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

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3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

Unfair Discrimination Against International Medical Graduates H-255.978

It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPIN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG. Reaffirmed: CME Rep. 01, A-20.

Oppose Discrimination in Residency Selection Based on International Medical Graduate Status D-255.982

Our AMA:

1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.

2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.

3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. Reaffirmation I-11.

Graduates of Non-United States Medical Schools H-255.983

The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character. Reaffirmed: BOT Rep. 25, A-15

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

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2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives,

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such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state. Reaffirmation: A-19.

Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309

1. Our American Medical Association:

A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.

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B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. CME Rep. 01, I-17.

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Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. Opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

2. Will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, andreligion during the residency and fellowship application process;

3. Will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;

4. Encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and

5. Will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 058
(November 2020)

Introduced by: Isabelle T. Yang, Chelsea Shannon, Sarah Matsunaga, Michael Koo, Lily J. Greene, Mariana L. Henry, Geisel School of Medicine at Dartmouth; Benjamin Wagner, University of Nevada, Reno School of Medicine; Jessica Mitter Pardo, Touro University College of Osteopathic Medicine

Sponsored by: Region 4, Region 6, Region 7, Association of Native American Medical Students

Subject: Prohibiting Evictions during Public Health Emergencies Caused by Infectious Pathogens

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, An estimated thirty to forty million Americans[1], or one in five Americans who live in renter households, were at risk of eviction by the end of calendar year 2020 due to expiring eviction moratoriums and stimulus benefits related to SARS-CoV-2 (COVID-19) without the Center of Disease Control's eviction moratorium issued on September 1, 2020 which covers all renters making under $99,000 per year, or double if filing taxes jointly, who have no other options except homelessness or living with others in close proximity[2-3]; and

Whereas, In response to the current COVID-19 public health emergency, forty-three states and Washington, D.C. enacted temporary eviction moratoriums for specific renters (e.g. renters in public housing, renters whose landlord's mortgage is insured by the Federal Housing Administration)[4]; and

Whereas, Initial federal protections prohibiting evictions expired on July 24, 2020, and as of July 31, 2020, 30 states offered no protection from evictions between July 31 and Sept 1, 2020 during the COVID-19 pandemic[2]; and

Whereas, 20+ million Americans have lost their jobs due to COVID-19[5], with many still remaining unemployed[6], causing record breaking lines at food pantries nation-wide as middle class families struggle to afford food[7]; and

Whereas, In the seventeen cities studied by the Eviction Lab, all eight cities with expired eviction moratoriums saw marked increases in weekly eviction filing rates pre- and post- eviction moratorium, such as Milwaukee's weekly average of 320 eviction filings in June compared to 15 eviction filings in May, due to the fact that state-specific eviction protections expired on May 26[8]; and

Whereas, Even in non-pandemic times, eviction has long-term, damaging health consequences for individuals[9-11] by interrupting treatment continuity and disrupting patient-provider relationships, increasing the likelihood of worsened health outcomes[12]; and

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Whereas, Evictions increase the risk of homelessness and housing instability, which have a well-documented role in worsening health and are associated with increased mortality and contribute to increased emergency room usage and demands on related healthcare resources[13-16]; and

Whereas, Homeless families resort to substandard living conditions, doubling up with friends or family members, living in temporary encampments, or entering the shelter system, further increasing their risk of exposure during public health emergencies caused by infectious pathogens[9, 11,17]; and

Whereas, The Secretary of the Department of Health and Human Services may determine that a public health emergency exists if either “a disease or disorder presents” a public health emergency or “significant outbreaks of infectious disease or bioterrorist attacks” cause a public health emergency[18]; and

Whereas, During public health emergencies caused by infectious pathogens, efforts should be made to increase availability and accessibility of critical health resources, specifically stable housing, through reallocation of funds, personnel, and related resources[18]; and

Whereas, AMA Policy D-130.974 encourages public health authorities to plan for the needs of the public during a crisis; and

Whereas, AMA policy H-160.903 establishes that housing and shelter is vital, and that the AMA supports policies that expand affordable and accessible housing nationally; therefore be it

RESOLVED, Our AMA advocate for federal policies that prohibit evictions during public health emergencies caused by infectious pathogens.

Fiscal Note: TBD

Date Received: 08/27/2020

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RELEVANT AMA AND AMA-MSS POLICY

Emergency Preparedness D-130.974

1. Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that

would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency.

(Sub. Res. 803, I-05 Reaffirmation A-06 Reaffirmed: BOT Rep. 2, A-07 Reaffirmed in lieu of Res. 938, I-11 Modified: BOT action in response to referred for decision Res. 415, A-12)

The Mentally Ill Homeless H-160.978
1. (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

(BOT Rep. LL, A-86 Reaffirmed: Sunset Report, I-96 Reaffirmed: CMS Rep. 8, A-06 Reaffirmed: CMS Rep. 01, A-16 Reaffirmed: BOT Rep. 16, A-19)

Eradicating Homelessness H-160.903
1. Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

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(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

(Res. 401, A-15 Appended: Res. 416, A-18 Modified: BOT Rep. 11, A-18 Appended: BOT Rep. 16, A-19 Appended: BOT Rep. 28, A-19)

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

(MSS Res 33, A-14; Reaffirmed: MSS GC Rep A, I-19)

Opposition to Measures That Criminalize Homelessness 440.066MSS
AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that requires non- discrimination against homeless persons, such as homeless bills of rights.

(MSS Res 20-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 059
(November 2020)

Introduced by: Arthur Orchanian, Lucas Werner, Ashton Lewandowski, Wayne State University School of Medicine; Alyssa Tuan, Penn State College of Medicine

Sponsored by: Region 5

Subject: Increasing Medication Delivery and Curbside Pick-Up During Pandemics

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In February 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first case of COVID-19 in the United States[1]; and

Whereas, As of August 21, 2020, the total number of cases in the United States of COVID-19 is more than 5,551,000, the total number of deaths is more than 173,000, and the incidence rate is 1,694 cases per 100,000 people[2]; and

Whereas, The CDC stated that, “COVID-19 seems to be spreading easily and sustainably in the community”[3], however the true infection rate is not known because many people who get infected by the virus may be asymptomatic[4]; and

Whereas, the World Health Organization stated that possible modes of transmission for SARS-CoV-2, the virus that causes COVID-19, include contact, droplet, airborne, fomite, fecal-oral, bloodborne, mother-to-child, and animal-to-human transmission[5]; and

Whereas, Certain populations such as individuals who are older and/or have underlying medical conditions are at greater risk of getting complications from an infection of SARS-CoV-2, such as respiratory illness ranging from mild disease to severe disease and death[6]; and

Whereas, those who depend on prescription medications are more susceptible to severe COVID-19 outcomes due to higher incidences of chronic conditions and advanced age compared to the general population[7]; and

Whereas, the act of grocery shopping, including picking up prescriptions from convenience stores or groceries with pharmacies, is rated as a “low-to-moderate” activity in terms of risk of contracting SARS-CoV-2[8]; and

Whereas, The CDC advises people at greater risk for COVID-19 complications to limit their interactions with other people as much as possible, continue their medications, and have at least a 30-day supply of prescription and non-prescription medications, among other recommendations[6]; and

Whereas, Pharmacists are advised to make physical and administrative changes to reduce their in-person interactions including, but not limited to, limiting paper transactions and switching to electronic methods of handling in-person materials such as insurance cards[9]; and

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Whereas, The CDC has advised patients who are deemed high risk to use alternative methods of medication pickup, including curbside pickup and home delivery of medications[9]; and

Whereas, Curbside medication pickup is often provided exclusively in limited areas or only at participating pharmacies[10,11,12]; and

Whereas, in a survey of 315 community pharmacists from around the country, 82.4% of respondents state that they had increased access to or added curbside pickup/home delivery and expect to continue those services after the current pandemic ends[13]; and

Whereas, Evidence suggests that the likelihood of pandemics has increased over the past century and could continue to increase[14], and

Whereas, While current AMA policy emphasizes the importance of timely distribution of medications, it does not address the safety of medication distribution methods in the setting of disasters or otherwise; therefore be it

RESOLVED, That our AMA amend current policy D-120.961 Personal Medication and Medical Supplies in Times of Disaster to address the safety of medication distribution methods by insertion as follows:

> **Personal Medication and Medical Supplies in Times of Disaster D-120.961**
> Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling <u>and safe distribution</u> of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.

RESOLVED, That our AMA amend current policy 120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy by insertion as follows:

> **120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy**: AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference; and <u>(3) That our AMA encourage pharmacies to adopt curbside pick-up and delivery programs for</u>

prescription medications to reduce the risk of transmission of infectious pathogens among patients who require prescriptions during all epidemics and pandemics.

Fiscal note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Personal Medication and Medical Supplies in Times of Disaster D-120.961
Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.
BOT Rep. 15, A-08; Modified: BOT Rep. 04, A-20

Personal Medication Supply in Times of Disaster H-120.942
Our AMA policy is that: (a) it is reasonable and prudent for patients with chronic medical conditions to maintain an emergency reserve of their prescription medications; (b) patients with chronic medical conditions should carry on their person a current list of their prescription medications, which includes indications, doses, and the prescriber's and dispensing pharmacist's contact information; and (c) patients with chronic medical conditions should discuss options with their physician for ensuring that they have an adequate supply of prescription medications in the event of a disaster or other potential emergency.
BOT Rep. 15, A-08; Reaffirmed: CSAPH Rep. 01, A-18

National Mail Order Pharmacy Practices H-120.962
1. The AMA insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment.
2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken.
3. Our AMA will make traditional pharmacies, including national chains, mail-order pharmacies, appropriate insurance carriers, and pharmaceutical benefit management companies aware of its policy opposing the charging of patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization

and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken.
Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmation A-14

Mail Order Pharmacies and Interface with Current Pharmacy Hubs H-120.940
Our AMA will: (1) work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians; and (2) advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems.
Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11

Mail Service Pharmacy H-120.989
The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs.
BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11

Improve Safety of Mail-Ordered Medication H-120.936
Our AMA supports the establishment of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency, and that when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient.
Res. 917, I-14

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Emergency Prescription Drug Refills H-120.933
Our AMA will advocate the following principles to guide the dispensing of emergency refills of prescription drugs:
1. Emergency refills should only be authorized if, in the pharmacist's professional judgment, failure to refill the prescription might result in an important interruption of a therapeutic regimen that could cause patient harm.
2. Emergency refills should only be dispensed if the pharmacy is unable to readily obtain refill authorization from the prescriber; prior authorization cannot be obtained in a timely manner from the patient's health plan; or when an emergency order or a proclamation of a state of emergency is declared by a state's governor.
3. Schedule II controlled substances can be dispensed on an emergency basis as allowed under Drug Enforcement Administration protocol.
4. In general, the pharmacist may dispense a sufficient supply of the medication to maintain the prescribed treatment until prescriber authorization can be achieved.
5. If an emergency order or proclamation of a state of emergency is issued by a state's governor, an executive order may allow pharmacists to dispense up to a 30-day supply of a prescription drug, or other amount as provided for under existing state law.
6. The dispensing pharmacist should notify the prescriber of the emergency refill within 72 hours of dispensing.
7. Emergency refills should not be a regular occurrence.
8. The pharmacist should inform the patient or the patient's agent at the time of dispensing that the refill is being provided without the prescriber's authorization and that authorization of the prescriber is required for a future refill.
9. The pharmacist should notify the patient or the patient's agent of any cost-sharing responsibilities prior to dispensing.
10. A prescriber should not be subject to liability for any damages resulting from an emergency refill of a prescription drug by a pharmacist.
CMS Rep. 3, I-15

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.

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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

American Pharmacists Association H-120.987
The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled.
Res. 147, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11

Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy H-120.939
Our AMA will support legislation or regulations that: (i) authorize physicians to cancel or rescind renewals of prescriptions previously written; (ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to- use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written; (iii) prevent such renewals from being filled or mailed to the patient; and (iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan.
BOT Rep. 8, A-11; Reaffirmation A-15

Preserving Patients' Ability to Have Legally Valid Prescriptions Filled H-120.947
1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.
2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner.
Sub. Res. 6, A-05; Appended: BOT Rep. 18, I-06; Reaffirmed and Appended: BOT Rep. 2, A-08; Reaffirmed: CMS Rep. 01, A-18

Adequate Prescription Medication Supply H-120.943
1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.

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2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis.
Res. 510, A-07; Reaffirmed: CMS Rep. 04, A-16; Appended: Res. 918, I-16

Bolstering Public Health Preparedness H-440.892
Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.
Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19

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

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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.
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

120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy: AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference
MSS Sub Res 23, A-05 Adopted; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934
1. Our AMA will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.

2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment

as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.

3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 060
(November 2020)

Introduced by: Alexandria Wellman, Matthew Riley, Southern Illinois University School of Medicine; Khalid Sheikh, University of Texas - Rio Grande School of Medicine

Sponsored by: Region 3, Association of Native American Medical Students

Subject: Encouragement of manufacturing necessary supplies within the United States

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The COVID-19 pandemic caused by the virus SARS-COV-2 has posed a huge global health crisis and a demand surge for essential medical supplies such as respirators and personal protective equipment (PPE), with estimates of 89 million medical masks alone needed each month to respond to the crisis[1]; and

Whereas, The United States has faced critical shortages of PPE and essential medical supplies due to disrupted global supply lines due to the reduced workforce, mandatory quarantine, and travel restrictions in countries manufacturing these necessary supplies [2,3,4]; and

Whereas, The current medical shortages have highlighted the United States' over-dependence on global supply chains for supplies essential for domestic healthcare and safety[5]; and

Whereas, A significant portion of American medical supplies are dependent on a single country, with 39.3% of medical device import lines to the United States supplied by the People's Republic of China and 13 of the 15 most commonly prescribed generic topical dermatology drugs dependent on Chinese manufacturers[7]; and

Whereas, Drug shortages cost hospitals hundreds of millions of dollars annually due to increased cost of drugs in short supply and have been attributed to patient safety issues, medical errors, and even patient deaths in the United States[8–10]; and

Whereas, The FDA has issued emergency use authorizations that have led to a ramp-up in domestic production of PPE and other essential medical supplies, although these authorizations are only valid during the duration of the COVID-19 pandemic[11]; therefore be it

RESOLVED, That our AMA advocate for the manufacturing and sourcing of necessary supplies and parts used in healthcare facilities, including but not limited to PPE, medications, cleaning supplies, hospital machinery, and personal hygiene products, to be predominantly located within the United States of America in order to prevent supply chain malfunctions in the event of a national emergency; and be it further

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RESOLVED, That our AMA advocate against the movement of factories producing manufactured goods used in healthcare and healthcare facilities by companies to production locations outside the United States of America; and be it further

RESOLVED, That our AMA support the locating of manufacturing of goods used in healthcare and healthcare facilities in regions of the United States that have low socioeconomic status and high unemployment rate, especially those regions affected by the prior loss of manufacturing and mining jobs; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

There is none that we could find.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 061
(November 2020)

Introduced by: Sabrina Hennecke and Shannon Wagner, University of Miami Miller School of Medicine.

Sponsored by: Region 4

Subject: Protection of Antibiotic Efficacy Through Water System Regulation.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Antibiotics have revolutionized medicine as treatments for previously-deadly diseases, and they remain an essential component of our modern armamentarium for effective clinical practice[1]; and

Whereas, The systemic overuse of antibiotics globally jeopardizes their effectiveness by increasing selection for and prevalence of antibiotic-resistant strains[2]; and

Whereas, The CDC predicts that at least 35,000 people die annually in the United States due to newer antibiotic-resistant strains of bacteria and fungi, and even this is likely an underrepresentation due to lack of data[3]; and

Whereas, The overuse of antibiotics for human and animal health leads to the transmission and expansion of the antibiotics, their transformant particles (TPs), antibiotic resistant bacteria (ABR), and antibiotic resistant genes (ARGs) into the environment, particularly via sewage systems[4]; and

Whereas, These components remain bioactive and are not effectively removed by treatment within wastewater plants[5]; and

Whereas, Antibiotic resistant bacteria may in fact propagate within wastewater treatment systems, where the high density of microorganisms facilitate efficient horizontal and vertical gene transfer of resistance genes[6,7]; and

Whereas, The accumulation of these byproducts pollute surface water, drinking water, groundwater, soil, and plants within areas irrigated by the impacted water, thereby transferring it back into humans through food and water and posing a significant health risk[4,8-11]; and

Whereas, Studies have identified aquaculture, domestic sources, pharmaceuticals, hospital and livestock wastewater, agriculture, and runoff from feedlots and fields fertilized by manure as a few of the key unregulated sources of antibiotic environmental pollution[12-15]; and

Whereas, The Clean Air and Clean Water Act of 1972 entrusts the Environmental Protection Agency (EPA) with regulation and monitoring of pollutants in order to “restore and maintain the chemical, physical, and biological integrity of the nation’s waters”[16,17]; and

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Whereas, The EPA's latest Contaminant Candidate List (CCL 4) includes Erythromycin, highlighting the antibiotic as a prevalent contaminant not currently subject to regulation under any national primary drinking water regulations but worth consideration for coverage under the Safe Drinking Water Act (SDWA)[18,19]; and

Whereas, Current AMA policy supports banning the use of antibiotics for non-therapeutic growth promotion in food-producing animals, surveillance of antibiotic use in agriculture (H-440.846) and supports monitoring groundwater sources for pollutants and efforts to improve waste treatment (H-135.943), but it lacks policy addressing antibiotic excess in water; and

Whereas, Existing AMA policy addresses water contamination by lead (H-135.928, H-60.918), pharmaceuticals (D-135.993), and chlorine (H-135.956), but does not address contamination by antibiotics and antibiotic components; and

Whereas, Numerous current AMA policies also endorse the creation of thresholds for environmental contaminants, especially when these contaminants are known to pose a risk to public health[20-33]; therefore be it

RESOLVED, That our AMA support legislation and regulation to address contamination, exposure, classification, and clean-up of antibiotics, their transformant particles (TPs), antibiotic resistant bacteria (ABR), and antibiotic resistant genes (ARGs) from public water supplies.

Fiscal Note: TBD

Date Received: 08/01/2020

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22. NAAQS Standard for Ozone, D-135.989. Mod. I-11.
23. Mercury Pollution, D-135.992. Mod. A-14.
24. Support Reduction of Carbon Dioxide Emissions, D-135.972. Mod. A-15.
25. Contamination of Drinking Water by Pharmaceuticals and Personal Care Products, D-135.993. Mod. I-16.
26. Human and Environmental Health Impacts of Chlorinated Chemicals, H-135.956. Mod. I-16.
27. Reducing Sources of Diesel Exhaust D-135.996. Mod. A-18.
28. Protective NAAQS Standard for Fine Particulate Matter (PM 2.5), H-135.946. Mod. A-19.
29. Research into the Environmental Contributors to Disease, D-135.997. Mod. A-19.
30. Safe Drinking Water, H-135.928. Mod. A-19.
31. Per- and Polyfluoroalkyl Substances (PFAS) and Human Health, H-135.916. I-19.
32. Preventing Death and Disability Due to Particulate Matter Produced by Automobiles, H-135.915. I-19.
33. Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10), D-135.978. Mod. I-19.

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RELEVANT AMA AND AMA-MSS POLICY

Antibiotic Use in Food-Producing Animals H-440.846

Our AMA supports: (1) federal efforts to ban antibiotic use in food-producing animals for growth promotion purposes, including through regulatory and legislative measures; (2) a strong federal requirement that antibiotic prescriptions for animals be overseen by a veterinarian knowledgeable of the place and intended use of these drugs, under a valid veterinarian-client-patient relationship (VCPR); and (3) efforts to expand FDA surveillance and data collection of antibiotic use in agriculture.

Expansion of Hazardous Waste Landfills Over Aquifers H-135.943

Our AMA: (1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed; (2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and (3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

Safe Drinking Water H-135.928

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by: (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers; (6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
(8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; (9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

Our AMA will: (1) advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure; (2) urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL; (3) advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to

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substitute lead for missing calcium as the children grow; (4) promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.

Contamination of Drinking Water by Pharmaceuticals and Personal Care Products D-135.993
Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956
The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 062
(November 2020)

Introduced by: Alexander Thebert, University of Kentucky College of Medicine; Austin Oslock, Ohio State University College of Medicine; Jerome Soldo, University of Louisville School of Medicine

Sponsored by: N/A

Subject: Environmental Sustainability of AMA National Meetings

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The World Health Organization (WHO) and our AMA have called climate change "the greatest public health challenge of the 21st century"[1,2]; and

Whereas, Reputable entities including the WHO, Intergovernmental Panel on Climate Change (IPCC), and U.S. Global Change Research Program assert that climate change has had an effect on, and continues to pose a great risk for, human health through climate related extreme weather events, worsening air quality, and increased disease transmission[1,3,4]; and

Whereas, Climate change is primarily driven through human activity and the release of greenhouse gases, including carbon dioxide, into the atmosphere[5]; and

Whereas, The U.S. Energy Information Administration has found that residential and commercial buildings make up 40% of total energy consumption in the U.S.[6]; and

Whereas, Leadership in Energy and Environmental Design (LEED) is the most widely used "green building" rating system in the world, and LEED-certified buildings have been shown to reduce energy consumption by 25% and emit 34% less carbon dioxide than typical buildings[7]; and

Whereas, Dozens of LEED-certified or sustainable convention centers exist throughout the United States and are already being utilized by medical conventions and societies[8-14]; and

Whereas, Transportation-related fossil fuel consumption is responsible for the largest proportion of U.S. greenhouse gas emissions, and domestic flights in the U.S. account for 17% of total global airline emissions[15,16]; and

Whereas, The AMA Annual Meeting would generate approximately 400 tons of carbon dioxide emissions from air travel if each HOD delegate and alternate delegate attendee (not including section members, friends, family, etc.) completed one mid-distance (800 mile) roundtrip flight, which would be the equivalent to the annual emissions from 20 U.S. residents[17,18,19]; and

Whereas, Carbon offsetting is the process of investing in emission-reducing activities such as renewable energy, high-efficiency products, and reforestation as a method to compensate for

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unavoidable carbon-generating activities; globally, carbon offsetting projects have prevented more than 1.8 billion tons of greenhouse gas emissions[20]; and

Whereas, The United Nations has acknowledged the importance of offsetting travel emissions from fossil fuels by passing a resolution that will require the purchase of carbon offsets for all international flights[21]; and

Whereas, Professional health organizations, including the American Public Health Association, are taking substantial actions to improve the environmental sustainability of their conferences by encouraging carbon offsets and choosing sustainable venues[22,23]; and

Whereas, Our AMA supports efforts to reduce the impact of fossil fuels on climate change, such as divestment, and encourages physicians to serve as spokespersons for environmental sustainability (H-135.921, H-135.973); and;

Whereas, Our AMA incorporates principles of environmental sustainability within its business operations (H-135.923); and

Whereas, Relocating future AMA meetings to LEED-certified or other sustainable conference centers and purchasing carbon offsets for AMA member travel are significant decisions that fall outside normal business operations and would benefit from additional study; and

Whereas, A GC action item with this resolutions' resolved clauses was submitted, but the MSS GC and AMA BOT members thought our asks were outside the scope of existing policy and would rather have them deliberated fully by the House of Delegates; therefore be it

RESOLVED, That our AMA will evaluate the feasibility of purchasing carbon offsets for member travel to and from annual and interim meetings and report back to the House of Delegates at the 2022 Interim Meeting; and be it further

RESOLVED, That our AMA will evaluate the feasibility of holding future annual and interim meetings at LEED-certified or sustainable conference centers and report back to the House of Delegates at the 2022 Interim Meeting.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

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Conservation, Recycling and Other "Green" Initiatives G-630.100
AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.
CCB/CLRPD Rep. 3, A-12, Modified: Speakers Rep., A-15

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
CSAPH Rep. 3, I-08, Reaffirmation A-14, Reaffirmed: CSAPH Rep. 04, A-19, Reaffirmation: I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

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1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.

2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
BOT Rep. 34, A-18

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA: (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Res. 924, I-16, Reaffirmation: I-19

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

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

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; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
CSAPH Rep. 1, I-08, Reaffirmation A-09, Reaffirmed in lieu of Res. 402, A-10, Reaffirmed in lieu of: Res. 504, A-16, Modified: Res. 516, A-18, Modified: Res. 923, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 063
(November 2020)

Introduced by: Alessandra Jimenez, Adaadinchezo Oguejiofor and Saba Suleman, University of Texas Rio Grande Valley School of Medicine; Varun Aitharaju and Sanjay Jinka, Northeast Ohio Medical University;

Sponsored by: Region 6, Association of Native American Medical Students

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Report

Referred to: MSS Reference Committee (Sarah Mae Smith, Chair)

Whereas, Race is a self-identified social construct that results in differential treatment of groups that leads to social inequity on people's health[1,2]; and

Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-identification of their origin or descent, "roots," heritage, or place where the individual, their parents, or ancestors were born[3]; and

Whereas, Race and ethnicity are assignations that are dependent on the self-identification and self-reporting of origin and/or cultural heritage[3,]; and

Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924); and

Whereas, Race or ethnic categorizations are not inherently biased and can shed light on health disparities that exist to inform intervention and policy[4,5]; and

Whereas, Racism is assigning value based on a person's appearance, leading to disparities that result in poorer health outcomes [1,3,4]; and

Whereas, Infant mortality rate among the college-educated white population was 5.4 per 1000 live births and infant mortality rate among the college-educated black population was 10.2 per 1000 live births[6]; and

Whereas, Hispanic children have the highest rates of COVID-19 related hospitalizations when compared with racial and ethnic groups within the same age group in the United States[7]; and

Whereas, In 2019, our AMA recognized racial and ethnic bias as a barrier to effective medical diagnoses and treatment (H-350.974); and

Whereas, COVID-19 case data published by the CDC in August 2020 reports health disparities that identified the most at-risk populations as "Hispanic and Black" demonstrating how medical professions use race and ethnicity interchangeably in data[7]; and

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Whereas, A current review examining ten studies and over 1.5 million participants demonstrated an association between ethnic and racial minorities including Black, Hispanic, South Asian, Southeast Asian, and Chinese, and delay time for medical care for chest pain in the emergency department[10]; and

Whereas, In practice, race and ethnicity are often interchangeably used as demonstrated in data collection practices for COVID-19 cases where the disaggregated data presented in these documents clearly outline “race/ ethnicity” in the same section of the presentation[7]; and

Whereas, Individuals included in the “Hispanic/ Latino” section of CDC reported data related to COVID-19 were not disaggregated by race, demonstrating that their ethnicity had been used in the place of race. Using the categories that the CDC outlined, an individual that identifies as Afro-Latinx would not be able to choose both a race and ethnicity and would fall under the heading of “multiracial” or “unknown” [7]; an

Whereas, Assumptions attributed to race and ethnicity can contribute to the inequitable treatment of patients as it relates to evidence-based medicine[10]; and

Whereas, Our AMA resolved to encourage physicians to examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other non-clinical factors, do not affect clinical judgment (H-350.974); and

Whereas, All individuals including medical professionals use cognitive schemas and heuristics in decision making that make them susceptible to using implicit bias[12]; and

Whereas, All individuals including medical professionals may not recognize signs of unconscious bias in their own practice[13]; and

Whereas, Prejudice contributes to cultural distrust of physicians due to racist actions experienced by the patient[14]; and

Whereas, Antiracism is the idea of supporting policy that through its action or implementation results in the advancement of racial justice, which is the deliberate use of systems and support to achieve and sustain racial equity through proactive and preventative measures[4]; and

Whereas, Our AMA Board of Trustees on June 7, 2020, recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of health care[11]; and

Whereas, A common cultural process in clinical practice is the use of race or ethnicity interchangeably in the first sentence of case report[2,16]; and

Whereas, Cultural processes are an acknowledged target for intervention for the advancement of health equity and antiracist policy[16]; and

Whereas, The headlining of race in case report has been discussed in association with premature differential diagnoses and proposed placement of this data in the family history section of the case[17]

Whereas, The presentation of race or ethnicity in the first sentence may impact medical decisions by contributing to implicit bias[16]; therefore, be it

RESOLVED, Our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports; and

RESOLVED, Our AMA encourages the maintenance of race and ethnicity in either social or family history of the patient; and

RESOLVED, Our AMA study common cultural processes in clinical practice that advance racism and bias.

Fiscal Note: TBD

Date Received: 9/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics 8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practice's physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

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Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

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(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Strategies for Eliminating Minority Health Care Disparities D-350.966:
Our American Medical Association **will continue to identify and incorporate strategies specific to the elimination of minority health care disparities** in its ongoing advocacy and public health efforts, as appropriate.

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; (3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and (4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.

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5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.

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

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

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65.018MSS: Preventing Discrimination against Patients by Medical Students:
AMA-MSS will ask the AMA to oppose the refusal by medical students to treat patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity

295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum:
That our AMA-MSS recognize that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; (2) That our AMA-MSS supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation.

350.020MSS Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities:
AMA-MSS will ask the AMA to: (1) amend H-315.996 by insertion to read as follows: Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records H-315.996: The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and (2) encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.

350.025MSS Racism as a Public Health Threat:
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies

295.193MSS Implicit Bias and Its Effects on Healthcare and Its Incorporation into Undergraduate Medical Education:
That our AMA-MSS recognizes the existence of implicit bias among health care clinicians; and be it further (2) That our AMA-MSS recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and be it further (3) That our AMA-MSS support medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients.

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65.005MSS Disseminating Information to Combat Ethnic Retaliation and Racism: AMA-MSS will work to raise awareness about incidents of ethnic retaliation and racism with the goal of reducing the occurrence of such incidents in the future.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 064
(November 2020)

Introduced by: Sam Genis, Ben Wagner, Natasha McGlaun, Katrina Marks, University of Nevada Reno School of Medicine; Jonathan You, Stanford University School of Medicine; Alice Shen, University of California San Diego School of Medicine; Monica Celine Fortich, University of Nevada Las Vegas School of Medicine; Kseniya Anishchenko, University of Colorado School of Medicine; Divy Mehra, Nova Southeastern University Kiran C. Patel College of Osteopathic Medicine

Sponsored by: Region 1

Subject: Opposition to Alcohol Industry Marketing Self-Regulation

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The American alcohol industry's political activity in opposition to federal regulation of its marketing venues is based on claims that its advertising practices are responsible and do not target youth, though there is a strong body of contradictory evidence to suggest that they consistently violate their own marketing guidelines with respect to youth-targeting behavior[1,9,10] and;

Whereas, The onset of binge drinking and hazardous drinking behaviors has been shown to have a stronger association with alcohol marketing exposure than with parental drinking status[2] and;

Whereas, Multiple studies have demonstrated that the alcohol industry's advertising practices disproportionately targets youth and has contributory effect toward the initiation and progression of youth drinking behaviors[3-5] and;

Whereas, The International Center for Alcohol Policies, an alcohol industry-sponsored organization whose role is to set standards of practice for alcohol marketing, states in its "Guiding Principles" that alcohol marketing communications should only be placed in media in which the audience composition is, at minimum, of 70% legal drinking age[6] and**;**

Whereas, Of the top 100 box office-grossing movies of each year from 1996-2009, alcohol brand placement increased in prevalence approximately 5% each year and was featured in 41% of top movies rated G, PG, PG-13 for children/adolescents, in direct violation of self-imposed industry standards[6, 7] and;

Whereas, Alcohol brand appearances in youth-rated movies trended upward from 1996 to 2009 from 80 to 145 per year, an increase of 5.2 appearances per year, indicating increased alcohol industry expenditure on brand placement in these movies[7] and;

Whereas, According to a 2015 report put forward by The Beer Institute, an American trade association which represents the alcohol industry's interests before Congress, the Institute

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alleges that the industry's marketing efforts direct consumer attention toward particular brands but do not encourage drinking in any segment of the population[8] and;

Whereas, A 2016 review of recent studies reveal evidence of a dose-dependent relationship between youth alcohol marketing exposure and subsequent initiation of drinking/progression to binge drinking behaviors[4] and;

Whereas, In a 2020 study it was demonstrated that global alcohol sales totaled over 1.5 trillion US Dollars, with the most spending focused in countries with limited industry marketing regulation and high youth alcohol marketing exposure levels[11] and;

Whereas, In regions of the world where the alcohol industry has self-regulated marketing codes, youth have consistently higher exposure to alcohol marketing[10] and;

Whereas, The youth population is considered a cohort particularly susceptible to socialization-based advertising techniques which intentionally pair products with agents of socialization in order to create favorable associations between the two in consumers' minds. Examples of this form of advertising, commonly employed by the alcohol industry, include product placement near-or usage by- popular television characters, social media campaigns, and the sponsorship of sporting teams, events, and celebrities. [11-13] and;

Whereas, The Master Settlement Agreement (MSA) was reached in 1999 between 46 state attorneys general and 4 tobacco manufacturers to resolve the largest class action lawsuit in American history; among its provisions, the MSA: forced the tobacco industry to make concessions/admissions of guilt regarding the ways in which their advertising practices disproportionately targeted the youth population, placed restrictions on advertising venues for the tobacco industry, and mandated that the industry pay out 206 billion dollars in reparations[14,15] and;

Whereas, Prior to the MSA the tobacco industry had self-regulatory standards for advertising practices, identical in nature to the current status of the alcohol industry[14,15] and;

Whereas, Following the MSA, youth cigarette usage has now dropped to the lowest levels seen in decades[16] and;

Whereas, A WHO Global Status Report on international alcohol policy demonstrated that up to 56% of countries worldwide have alcohol marketing regulations to protect youth and other vulnerable populations from the harmful effects of alcohol marketing[17] and;

Whereas, The United Nations Convention on the Rights of the Child declares it the responsibility of sovereign nations to create appropriate guidelines to protect children from information and material injurious to their wellbeing[18] and;

Whereas, A 2017 study demonstrated that there is no effective system currently in place to remove- or enforce punitive measures for production of- advertisements deemed "non-compliant" to the American alcohol industry's self imposed 'youth-protective' advertising regulations[9,10]; therefore be it

RESOLVED, That our AMA amend policy H-30.940, Labeling Advertising, and Promotion of Alcoholic Beverages, by addition and subtraction as follows:

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H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) Supports federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol industry's current practice of self-regulated advertising and marketing; ~~(a)~~(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes ~~the use of the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and

~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including ~~such as~~ promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

Fiscal note: TBD

Date received: 08/01/2020

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RELEVANT AMA POLICY:
Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940
(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

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(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973
1. Our AMA will advocate for a ban on the marketing of products such as flavored malt liquor beverages, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age.

Alcohol and Youth D-170.998
Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 065
(November 2020)

Introduced by: Kevin Brittan, Creighton University School of Medicine; Steven Graefe, Jenna Heil, Bahareh Jabbari, Alex Johar, Abigail Jones, Mary Grace Kenny, Alvina Le, Austin Le, Patrick Marta, Hannah Meissner, Nathan Ostlie, Vinootna Sompalli, Jordan Terschluse, Elise Tidwell, Arjun Vadlamudi, Creighton University School of Medicine

Sponsored by: Region 2

Subject: Investigation of Naturopathic Vaccine Exemptions

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Washington State placed into effect a law that allowed for licensed naturopaths to grant medical exemptions for required vaccines[1]; and

Whereas, The strictness of state vaccination exemptions directly correlates with the incidence of preventable disease[2]; and

Whereas, The World Health Organization has identified vaccine hesitancy as one of the top ten threats to global health[3]; and

Whereas, Individuals who obtain exemptions are more likely to seek health care from naturopaths and are less likely to trust physicians and vaccine information[4]; and

Whereas, The 1991 canon of American Association of Naturopathic Physicians recommends delaying administration of vaccines until after 2 years of age[6]; and

Whereas, Those in Washington State who received care from naturopathic physicians or chiropractors at ages < 2 years were significantly less likely to receive the four following vaccinations: measles/mumps/rubella, chickenpox, diphtheria/tetanus/pertussis and H. influenzae type B[7]; and

Whereas, Naturopathic care corresponded with reduced rates of vaccination at odds ratios of 0.22 for measles/mumps/rubella, 0.23 for chickenpox, 0.30 for diphtheria/tetanus[5]; and

Whereas, No naturopaths endorsed the vaccines needed to prevent rotavirus or the hepatitis B vaccine administered at birth[6]; and

Whereas, Only 20% of naturopaths actively recommend vaccination to their patients[5]; and

Whereas, Our AMA believes nonmedical exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large[8]; therefore be it

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RESOLVED, Our AMA opposes medical vaccine exemptions by naturopathic physicians; and be it further

RESOLVED, Our AMA advocates for state and national legislation opposing the ability of naturopathic physicians to provide medical vaccine exemptions.

Fiscal Note:

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

H-440.992: <u>National Immunization Program</u>
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease:
1. All US children should receive recommended vaccines against diseases in a continuing and ongoing program.
2. Immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.

H-440.970: <u>Nonmedical Exemptions from Immunizations</u>
1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations

H-440.830: <u>Education and Public Awareness on Vaccine Safety and Efficacy</u>
1. Our AMA supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation;

H-440.877: Distribution and Administration of Vaccines
Physicians and other qualified health care providers should:
1. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 066
(November 2020)

Introduced by: Naeha Haridasa, Varsha Parthasarathy, The George Washington University School of Medicine and Health Sciences; Alicia Khan, The Georgetown University School of Medicine

Sponsored by: N/A

Subject: Standardization of Intimate Partner Violence Screening within Clinical Settings

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, 1 in 4 women and 1 in 10 men in the United States (US) have experienced intimate partner violence (IPV), such as contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and nearly half of female homicide victims in the US were killed by a current or former male intimate partner[1]; and

Whereas, Most victims of IPV additionally report some form of IPV-related impact including PTSD, depression, substance abuse, chronic systemic health issues, concern for safety, severe physical injury, and death, etc.[2]; and

Whereas, IPV screening methods in healthcare settings have been shown to vary widely across institutions, with 41.6% out of 1,208 nationwide primary care, OB/GYN, and emergency department institutions unable to describe which screening tool they used or examples of questions they ask patients[3]; and

Whereas, A statewide survey of providers found that only 14% report consistently screening female patients for IPV and one third report never screening[4]; and

Whereas, Most providers lack confidence in IPV screening, referral, and record-keeping[5], with the most frequently reported resource barriers being lack of knowledge, education, or training regarding screening of abuse[6]; and

Whereas, Staff training alone does not result in increases in rates of domestic violence identification and referral, but staff training and systemic changes (e.g. standardized documentation forms and screening tools, electronic medical record coding, and specific interpersonal violence advisors) demonstrate increases in identification of victims of IPV and referral to necessary resources[7]; and

Whereas, Pre-existing screening tools in the electronic medical record can help providers by leading to an increased perception of screening readiness, with significant improvement in quality of screening including “professional role resistance/fear of offending the patient”, “blame victim items”, “perceived self-efficacy”, and “victim/provider safety”[8]; and

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Whereas, The United States Preventive Services Task Force (USPSTF) has found adequate evidence of screening instruments that can effectively identify IPV in women[9]; and

Whereas, The CDC (Centers for Disease Control) has several recommended screening tools, such as the AAS (Abuse Assessment Screen)[8] and HITS (Hurt, Insult, Threaten, and Scream)[10] that have high research-based sensitivity and specificity for successfully identifying victims of IPV; and

Whereas, Even with screening, referral processes are also not standardized, with only 40.2% of 1,208 healthcare facilities reporting that their policies for identifying and responding to IPV were written formally somewhere in the facility[3]; and

Whereas, Current AMA policy recommends generalized “routine inquiry” about interpersonal violence (IPV) in a clinical setting without an emphasis on utilizing standardized evidence-based screening tools, (H-515.965); therefore it be

RESOLVED, That the AMA amend Policy H-515.965, “Family and Intimate Partner Violence”, by addition to read as follows:

Family and Intimate Partner Violence, H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and

procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Utilize standardized, evidence-based screening methods which prioritize patient safety and confidentiality in clinical settings; (c) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (d) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (e) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (f) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (g) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (h) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (i) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (j) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (k) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

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(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and

human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Fiscal Note: TBD

Date Received: 09/20/2020

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MSS Res 15, I-15

RELEVANT AMA AND AMA-MSS POLICY

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to

the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical

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formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00Reaffirmed: CSAPH Rep. 2, I-09Modified: CSAPH Rep. 01, A-19

Education of Medical Students and Residents about Domestic Violence Screening H-295.912

The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. Res. 303, I-96Reaffirmed: CME Rep. 2, A-06Reaffirmed: CME Rep. 01, A-16

Intimate Partner Violence Policy and Immigration D-515.979

Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status. Res. 002, I-17

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ)

Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of (IPV); (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of (IPV); (3) advocate for federal funding to support programs and services for survivors of (IPV) that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of (IPV) in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. Res. 903, I-17Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities,

and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. CSA Rep. I, A-92Reaffirmed: CSA Rep. 8, A-03Modified: CSAPH Rep. 1, A-13

8.10 Preventing, Identifying and Treating Violence and Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

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(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients. Issued: 2016

Teaching Domestic Violence Screening 295.078MSS

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

Education of Medical Students About Domestic Violence Histories 295.079MSS

AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk. (AMA Amended Res 303, I-96 Adopted [H295.912]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Identifying Victims of Adult Domestic Violence 515.001MSS

AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals 65.023MSS

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

> **Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H65.976**
>
> Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

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

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H160.991

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

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

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

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ+ people. MSS Res 10, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 067
(November 2020)

Introduced by: Shirin Dey, Keyanna Jackson, Ronald Nelson, Columbia University Vagelos College of Physicians and Surgeons

Sponsored by: Association of Native American Medical Students

Subject: Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The clinical learning environment is not equal for all medical students, as evidenced by a cohort study of 27,504 graduating medical students showing that 23.3% of under-represented medical students experienced mistreatment in the form of racial/ethnic discrimination, compared to 3.8% of white students[1]; and

Whereas, Under-represented medical students report receiving lower evaluations on the basis of their race, as demonstrated at University of Washington School of Medicine where, out of 892 medical students surveyed, white students were up to twice as likely to receive high scores on clinical evaluations and better final clerkship grades as students of color after adjusting for USMLE Step 1 scores[2]; and

Whereas, Data from another peer school, University of California San Francisco, showed that from 2013-2016, under-represented students received approximately half as many honors grades on average as non-under-represented students in clinical clerkships[3]; and

Whereas, The impact of discriminatory clinical year grading practices is not limited to the clinical year itself, given that a *JAMA Internal Medicine* study of 4,655 Electronic Residency Application Service (ERAS) applications found, after adjusting for United States Medical Licensing Examination (USMLE) Step 1 score, graduate degrees, and factors such as publications, an individual Black student has 16% of the chance a white student has of being granted Alpha Omega Alpha (AOA) admission[4]; and

Whereas, With regards to the teacher-learner relationship, our AMA condemns discrimination based on race (H-295.955); and

Whereas, Though our AMA-MSS has put forth policy that asks our AMA to advocate for blinded grading whenever possible as well as implicit bias training for all scorers, clerkship grading is largely unblinded aside from standardized exams (295.210MSS); and

Whereas, Encouraging the establishment of a less subjective grading system such as two-interval grading to minimize racial bias would further our AMA's current aims of enhancing racial and ethnic diversity in medicine, ensuring equal opportunity and quality of clinical clerkships for medical students, and eliminating discrimination in the residency application process (H-310.919, D-295.309, H-295.969); therefore be it

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RESOLVED, Our AMA-MSS will research the ability of two-interval grading of clinical clerkships to minimize racial bias in medical education.

Fiscal Note: TBD

Date Received: 09/20/2020

References:

1. Hill, K. et al. Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation. JAMA Intern Med. 2020;180(5):653–665. \
2. Low, D. et al. Racial/Ethnic Disparities in Clinical Grading in Medical School. Teach Learn Med. 2019;31(5):487-496.
3. Teherani, A. et al. How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards: A Cascade With Serious Consequences for Students Underrepresented in Medicine. Acad Med. 2018;93(9):1286-1292.
4. Boatright, D. et al. Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society. JAMA Intern Med. 2017;177(5):659–665.

RELEVANT AMA AND AMA-MSS POLICY

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

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Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

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3. will continue to support efforts to enhance **racial** and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;

4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize **bias** in the ERAS and the residency training selection process; and

5. will advocate that modifications in the ERAS Residency Application to minimize **bias** consider the effects these changes may have on efforts to increase diversity in residency programs.

Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.

2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially

when the presence of visiting students would disadvantage the institution's own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.

3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.

4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.

5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

Nondiscrimination Toward Residency Applicants H-295.969
Our AMA urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."

Requiring Blinded Review of Medical Student Performance 295.210MSS
AMA-MSS will ask the AMA to work with appropriate stakeholders, such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) to support: (1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students, and (2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring. (MSS CME Report A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 068
(November 2020)

Introduced by: Anmol Gupta, Ryan Nowrouzi, Baylor College of Medicine

Sponsored by: Region 3

Subject: Authorize Competitive Licensing when Medicare Negotiation Fails

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, One in four Americans report being unable to fill a prescription due to unaffordable prices[1]; and

Whereas, The United States spends $858 per capita on prescription drugs, comprising 17% of overall personal health spending[2]; and

Whereas, Currently, a majority of new drugs that come to market are developed with tax-payer dollars[3]; and

Whereas, Between 2010 and 2016, all 210 new drugs approved by the FDA were the result of research supported by $100 billion of federal taxpayer funds[3]; and

Whereas, A majority of the research involved in the production of new FDA approved drugs between 2010 and 2016 was associated with basic research of biological targets and drug action that is primarily conducted at universities receiving federal grant funds (such as from the NIH), making the public the de facto largest funder of biomedical research and development (R&D) in the world[3]; and

Whereas, This publicly funded research often does not result in affordable medicines; instead, universities and medical colleges often patent the developments of this publicly funded research and exclusively license these patents to large pharmaceutical companies who hold monopoly power to charge exorbitant prices[4]; and

Whereas, Two recent examples, Kymriah and Yescarta, two CAR-T cell therapies are priced above 300,000 dollars, despite both being products of NIH supported research and Kymriah being directly licensed from the NIH[5]; and

Whereas, One example includes the University of California, which exclusively licensed three patents for the prostate cancer drug Xtandi--all made possible by tax-payer funded with a NIH SPORE grant and a grant from the Department of Defense--to Medivation Inc. in 2005[6]; and

Whereas, Federal funding from the National Cancer Institute and Department of Defense was involved with both Phase 1 and Phase 2 of the clinical testing of Xtandi[6]; and

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Whereas, Regents of the University of California subsequently sold their royalty rights to Royalty Pharma for $520 million in 2016[6,7,8]; and

Whereas, Pfizer, which holds the licensing rights for Xtandi today, sells the drug for more than $125,000 per year per patient[6,8]; and

Whereas, Another example includes Northwestern University, which obtained approximately $700,000 in NIH funding in 1987, leading to the development of Pregabalin which was subsequently licensed to Warner-Lambert[9,10]; and

Whereas, Northwestern University sold its royalties for $700 million, with a majority of funds going directly into the school's endowment, rather than further R&D investments[9,10]; and

Whereas, Meanwhile, the corporations that hold rights to these licenses proceed to hold monopolies on these medicines and employ tactics such as evergreening to extend the length of these patents, in an effort to extend monopolies and keep prices as high as possible[11]; and

Whereas, 74% of new patents between 2005 and 2015 were issued on existing drugs, while 80 of the best-selling drugs obtained extended exclusivity protections to delay entry of generics to market[12]; and

Whereas, In response to the rising costs of drug prices, the American Medical Association Policy D-330.954 supports "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", indicating support for Medicare, the largest purchaser of prescription drugs, to have the power to negotiate pharmaceutical pricing; and

Whereas, However, it is unclear that restoring the power to negotiate drug prices in of itself will be enough to substantially lower drug prices as no serious proposal has indicated what form of leverage the government agency would have to effectively negotiate[13,14]; and

Whereas, Currently, no safeguards have been identified in the instance that a drug company refuses to negotiate in good faith or that the two parties fail to arrive at a negotiated settlement--leaving Medicare unable to buy a drug, subsequently creating barriers to access risking the health of thousands of Medicare recipients[13,14,15]; and

Whereas, Some lawmakers and policy advocates have suggested that arbitration or international reference pricing could be mechanisms for Medicare negotiation, however current proposals to do so may prove ineffective if companies are able to opt out without little consequence in the instance that they are unsatisfied with an arbiter's set prices--thus letting companies hold on to monopoly power to create artificial and uncompetitive markets for their drugs[2]; and

Whereas, To ensure Medicare has leverage in price negotiations, Medicare should not only negotiate prices directly but also use competitive or compulsory licensing authority to grant non-exclusive licenses to third-party manufacturers as a means of authorizing generic competition when a negotiation fails[2,16,17]; and

Whereas, Compulsory or compulsory licensing policy tied to Medicare negotiation authority does not allow any drug manufacturer to walk away and guarantees the ability for the government to ensure generic competition if an agreed-upon price is not reached[2,16,17]; and

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Whereas, Competitive and compulsory licensing breaks monopolies and not patents, only allowing a government-authorized manufacturer to compete in generic production[6]; and

Whereas, The U.S. Government has already enacted clear safeguards through the Bayh-Dole Act which, allowing the Government to provide licenses to third party manufacturers to introduce competition into the market when a pharmaceutical company has not made the technology available under reasonable terms[6,18]; and

Whereas, Current patent law (28 U.S.C. section 1498) provides the government immunity from patent claims where infringement serves the public good while still affirming patent holders to receive reasonable compensation where the government authorizes production of an equivalent [16,19]; and

Whereas, Current patent law (35 U.S.C section 203) requires university patents derived from government-funded research to include “government interest” statements allowing the government to retain march-in-rights, however research has shown these statements are often omitted and the requirement is not enforced[20,21,22]; and

Whereas, The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) between all member nations of the World Trade Organization (WTO), authorizes compulsory licensing under certain circumstances, such as public health emergencies[17]; and

Whereas, The 2001 Doha Declaration on the TRIPS Agreement, unanimously adopted by all WTO member states, grants “each member [...] the right to grant compulsory licenses and the freedom to determine grounds upon which such licenses are granted”[23]; and

Whereas, However, few compulsory licenses have been issued under any existing laws or agreements, primarily due to cited perceptions that compulsory licenses negatively impact incentives for innovation[17]; and

Whereas, A report from the Eastman Commission found that Canada’s practices of compulsory licensing had little to no adverse impact on licensor innovation[17]; and

Whereas, An analysis of six compulsory licenses of drug patents in the U.S., published in the Berkeley Technology Law Journal, finds that rates of patenting and other measures of inventive activity by affected entities did not decline after a compulsory license was issued[17]; and

Whereas, There exist several examples of competitive licensing in the United States and abroad; and

Whereas, In 2003, Malaysia issued competitive “government-use” licenses on three patented AIDS medicines, allowing the government to import generic versions from India and reduce the Malaysian Ministry of Health’s average cost to treat one person per month down to $58 from $315[24,25]; and

Whereas, The mere threat of a competitive license from the United States government forced Bayer to drastically reduce their price of ciprofloxacin in 2001, as the government prepared stockpile of the drug in defense against anthrax[26]; and

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Whereas, Today there exists proposed legislation (H.R. 1046) with 127 House of Representative co-sponsors that creates a clear safeguard for failed negotiations, allowing the Secretary of HHS to license patents or other exclusivities tied to a drug when Medicare and a manufacturer are unable to agree upon a price, opening a route for generic lower cost production to compete in the market while providing the patent holder reasonable compensation[27,28]; and

Whereas, Competitive licensing aims to provide Medicare with the effective leverage needed to incentivize good-faith negotiations and to continue to have an avenue of lowering drug prices for Medicare beneficiaries in the event of an unsuccessful negotiation; therefore be it

RESOLVED, That the AMA will amend D-330-954 as such

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.~~ negotiate prices with drug manufacturers and issue competitive licenses if negotiations fail to reach an agreed-upon price for all Part D covered 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 and issue necessary competitive licenses to ensure end-user affordability for all applicable medications covered by CMS.

Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

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.

Res. 211, A-04Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14

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Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will 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:
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 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;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will 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:
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;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

3. Our AMA supports 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.
Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
CMS Rep. 4, I-19

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.

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

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Sub. Res. 106, A-15 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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 069
(November 2020)

Introduced by: Danielle Rivera, Leslie Jade Archuleta, University of New Mexico School of Medicine; Sarah Joseph, Texas A&M College of Medicine; Kiersten Woodyard, University of Cincinnati College of Medicine; Avneet Soin, Tufts University School of Medicine

Sponsored by: Region 1, Region 4

Subject: Opposition to the Criminalization of Perinatal Demise

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The terms “miscarriage” or “spontaneous abortion” are generally defined as a nonviable intrauterine pregnancy up to twenty weeks gestation[1,2]; and

Whereas, The terms “late fetal demise,” “fetal loss,” “stillbirth,” and “stillborn,” all refer to the delivery of a fetus with twenty or more weeks of gestation without signs of life[1], and

Whereas, The term “perinatal loss” encompasses the death of a fetus or infant who dies due to miscarriage, stillbirth, or neonatal death[3]; and

Whereas, Thirty-eight states have fetal homicide and/or fetal demise laws which allow someone to be charged with harm or murder of the unborn fetus outside of legal abortion[4]; and

Whereas, While these laws have been historically used against perpetrators who assault or murder pregnant females, these laws are now being used against pregnant women themselves[5,6]; and

Whereas, In 2019, women in both California and Tennessee were charged with murder, one after a premature delivery resulted in the death of her fetus and the other after a stillbirth, when, in both instances, the fetuses tested positive for drugs[5,6]; and

Whereas, In 2011, an Indiana woman was tried for murder after a suicide attempt that resulted in an emergent c-section and subsequent death of her baby few days later[7]; and

Whereas, Addiction is considered a medical disorder since it involves “functional changes” to neural circuitry involving reward, self-control, and stress that last even after substance use has ceased[8]; and

Whereas, Twenty-three states consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and twenty-five require health care professionals to report suspected prenatal drug use[9]; and

Whereas, these laws were created as part of the “War on Drugs” and not as policies to promote public health or improved neonatal outcomes[10]; and

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Whereas, A PLOS study found that laws requiring mandatory warning signs about the risk of alcohol use in pregnancy and laws that classify alcohol or drug use during pregnancy as child abuse were associated with worse neonatal outcomes, including lower birth weights, lower APGAR scores, and more pre-term births[11]; and

Whereas, The aforementioned study suggests that laws that declare substance use as child abuse or neglect are the harming the very women and fetuses they seek to help[11], and

Whereas, Both fetal demise laws and classification of substance use during pregnancy as child abuse infringe on pregnant person's rights, protections, and autonomy[12]; and

Whereas, Research has found that cases involving pregnant women of color who have substance-use disorders are referred to child protective services at higher rates than those involving white women[13,14]; and

Whereas, Laws that classify substance use during pregnancy as child abuse and criminalize per inatal death act to reduce trust within the patient-doctor relationship, preventing pregnant women with substance use disorders from being able to honestly discuss their health without risk of prosecution[15]; and

Whereas, AMA policy H-420.970 already opposes the criminalization of addiction during pregnancy, but does not directly address the criminalization of fetal loss in patients with addiction or other medical conditions, such as mental health disorders; therefore so be it

RESOLVED, That AMA policy H-420.970 be amended by addition and deletion as follows:

> **Treatment Versus Criminalization - Physician Role in Drug Addiction <u>and Mental Health Crises</u> During Pregnancy <u>and the Perinatal Period</u> H-420.970**
>
> It is the policy of the AMA (1) to reconfirm its position that drug addiction <u>and mental health crises, including but not limited to sudiciality,</u> ~~is a~~ <u>are conditions</u> ~~disease~~ amenable to treatment rather than a criminal activity;
> (2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
> (3) to oppose legislation which criminalizes maternal drug addiction <u>and other mental health disorders</u> or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
> (4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
> <u>(5) to advocate against the criminalization of perinatal loss in women who experience known medical conditions, including addiction or other mental health disorders during pregnancy.</u>

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Fiscal Note: TBD

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RELEVANT AMA AND AMA-MSS POLICY

Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970

It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;

(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;

(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and

(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
Res. 131, A-90,Reaffirmed: Sunset Report, I-00,Reaffirmed: CEJA Rep. 6, A-10

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse;

(2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;

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(3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and

(4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.
Res. 209, A-18,Modified: Res. 520, A-19

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. CSA Rep. G, A-92, Reaffirmation A-99, Reaffirmation A-09, Modified and Reaffirmed: CSAPH Rep. 1, A-09, Modified: Alt. Res. 507 A-16, Modified: Res. 906, I-17, Reaffirmed: Res. 514, A-19

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:

(1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.

(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.

(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.

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(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.

(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.
BOT Rep. OO, A-90,Reaffirmed: Sunset Report, I-00, Reaffirmed: CEJA Rep. 6, A-10, Reaffirmed: Res. 507, A-16, Reaffirmed: Res. 209, A-18

Oppose the Criminalization of Self-Induced Abortion H-5.980
Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and

(2) will advocate against any legislative efforts to criminalize self-induced abortion.
Res. 007, A-18

Drug Testing H-95.985
Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:
1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.
3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.
4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued. (CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 01, I-16)

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Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09)

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 070
(November 2020)

Introduced by: Christopher Wong, Baylor College of Medicine; Eve Swirski, Rutgers New Jersey Medical School; Kaylin Beiter, Annette Hebert, Louisiana State University School of Medicine; Sean Cody, Western Michigan University Homer Stryker M.D. School of Medicine; Rohan Khazanchi, Elena Blusys, Olivia Sonderman, University of Nebraska Medical Center; Natasha Topolski, McGovern Medical School

Sponsored by: Region 1, Region 3, Region 4, Region 5

Subject: Ethical Guidance for Short-Term Medical Service Trips

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Short-term medical service trips (STMSTs) are defined as trips in which volunteer medical providers travel to low and middle-income countries (LMICs) to provide health care over periods ranging from 1 day to 8 weeks[1]; and

Whereas, There has been significant growth in the use of STMSTs as a means to provide care to communities in LMICs[1-3]; and

Whereas, There is a gap in research regarding the efficacy and sustainability of STMSTs[1,4-6]; and

Whereas, STMSTs undertaken by individuals with limited medical training may unintentionally cause long-term harm to the communities they intend to help due to non-judicious use of medical supplies and disruption of the growth of, effectiveness of, and community trust in the local health system[4,7-10]; and

Whereas, STMSTs undertaken by experienced medical professionals who are not culturally competent to the region in which they are providing care may also cause harm[11,12]; and

Whereas, The interests (educational or otherwise) of organizations hosting STMSTs can conflict with the health interests of local communities the programs seek to serve[2-4,6,13]; and

Whereas, AMA policy H-250.993 addresses ethical standards for medical students engaging in global health work as part of their medical education, but does not address physicians or students participating in volunteer STMSTs; and

Whereas, AMA Code of Medical Ethics 7.3.3 covers ethical guidelines for international research, but not international practice or service; and

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Whereas, There are no other guidelines in the AMA Code of Ethics that set standards for international work, despite a significant body of work specifically calling for the development of such guidelines[10,12,14,15]; and

Whereas, Within an issue of the AMA Journal of Ethics dedicated to global health immersion in health professions education, the ethical norms of adequate preparedness, continuity of care, competence, collaboration, sustainability, and outcomes monitoring are emphasized as benchmarks to guide evaluation of short-term medical service trips[16]; and

Whereas, The American College of Physicians and the American Association of Medical Colleges have endorsed principles such as sustainable change, cultural sensitivity, pre-departure preparation, and partnerships with local organizations in order to guide their membership in participating in STMSTs in an ethical manner[17,18]; therefore be it

RESOLVED, That our AMA-MSS supports fundamental ethical standards for short-term medical service trips that include: (1) ensuring that programs have legitimate community partnerships that guide culturally sensitive and sustainable work based on community-identified needs; (2) volunteer cultural competency training including specific education on the local community norms and the principles of nonmaleficence and beneficence in the context of the trip objectives; and (3) emphasis on empowerment of local communities in the form of health professional and community education.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics - 7.3.3 International Research

Biomedical and health research in international settings often raises special ethical questions, particularly when research is carried out in resource-poor settings by sponsors or researchers from resource-rich countries. Physicians engaged in international research may encounter differing cultural traditions, economic conditions, health care systems, and ethical or regulatory standards and traditions than in the US.

While fundamental requirements to ensure scientifically sound research and to protect the welfare, safety, and comfort of human participants apply in any research setting, physicians who are involved in international research may need to address special concerns about selection of research topic and study design, informed consent, and the impact of the research on the participating community.

In addition to following general ethical guidelines for biomedical and health research, physicians who are involved in international research have obligations to:

Study design

(a) Ensure that the research responds to a medical need in the region in which it is undertaken.

(b) Ensure that the research does not exploit the populations and communities from which participants will be drawn.

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(c) Be sensitive to special considerations in assessing the risks and benefits of the research in the particular setting and employ a research design that minimizes risks to the participant population by:

(i) ascertaining that there is genuine uncertainty within the clinical community about the comparative merits of the experimental intervention and the intervention that will be offered as a control for the population to be enrolled;

(ii) obtaining relevant input from representatives of the host community and from the research population;

(iii) considering the harm that is likely to result for the host community or research population if the research is not carried out.

(d) In some instances, a three-pronged protocol that offers the standard of care in the US, an intervention that meets a level of care that can be attained in and sustained by the host community, and a placebo may offer the most ethically desirable means for evaluating the safety and efficacy of an intervention in a given population.

Informed consent

(e) Ensure that a suitable process for informed consent is in place. If consent is to be meaningful, physicians (or other health professionals) who obtain consent must communicate with sensitivity to local customs. Notwithstanding, they should always ensure that individual participants are informed and that their voluntary consent is sought.

Impact on the host community

(f) Foster research with the potential for lasting benefits to the host community, especially when the research is carried out among populations that are severely deficient in health care resources. This can be achieved by:

(i) facilitating development of a health care infrastructure that will be of use during and after the research period itself;

(ii) encouraging sponsors to provide interventions that have been demonstrated to be beneficial to all study participants after the study concludes.

Medical Care in Countries in Turmoil H-65.994
The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems. Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15

A Declaration of Professional Responsibility H-140.900
Our AMA adopts the Declaration of Professional Responsibility

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DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble
Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration
We, the members of the world community of physicians, solemnly commit ourselves to:
(1) Respect human life and the dignity of every individual.
(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
(3) Treat the sick and injured with competence and compassion and without prejudice.
(4) Apply our knowledge and skills when needed, though doing so may put us at risk.
(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
(7) Educate the public and polity about present and future threats to the health of humanity.
(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
(9) Teach and mentor those who follow us for they are the future of our caring profession.
We make these promises solemnly, freely, and upon our personal and professional honor.
Issued: 2016

Professionalism in Medicine H-140.951
Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity. Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09; Consolidated: CEJA Rep. 03, A-19

AMA and Public Health in Developing Countries H-250.986
Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the

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World Health Organization. BOT Rep. 5, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18

Overseas Medical Education Developed by US Medical Associations H-250.993
The AMA will:
(1) continue to focus its international activities on and through organizations that are multinational in scope;
(2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world;
(3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world;
(4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities;
(5) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and
(6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives. CME Rep. 6, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: CME Rep. 9, A-12; Modified: Res. 303, A-16

Enhancing Young Physicians' Effectiveness in International Health H-250.996
It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11

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

> H-250.993 Overseas Medical Education Developed by US Medical Associations
>
> The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among

medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives.(CME Rep. 6, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: CME Rep. 9, A-12)

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 071
(November 2020)

Introduced by: Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Oluwasegun Emenogu, University of Toledo College of Medicine and Life Sciences; Hirsh Shah, University of Toledo College of Medicine and Life Sciences; Megan Chiu, Indiana University School of Medicine; Neha Siddiqui, Carle Illinois College of Medicine; Amber Gautam, Brody School of Medicine at East Carolina University

Sponsored by: Region 5

Subject: Consent Reform as a Protective Method for Victims of Human Trafficking

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The United States ranked amongst the world's worst countries for human trafficking in 2018[1]; and

Whereas, The United States Department of Justice defines human trafficking as a crime that involves exploiting a person for labor, services, or commercial sex[2]; and

Whereas, The Trafficking Victims Protection Act of 2000 and its subsequent reauthorizations define human trafficking as sex trafficking and the exploitation of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery[2]; and

Whereas, Human trafficking is a continuously rising issue, with a 25% increase in cases from 2017 to 2018[3]; and

Whereas, 10,949 cases of human trafficking were reported in 2018, the highest of any single year. Nearly 8,000 of these were sex trafficking cases, and 51.6% of victims were under the age of 18[4]; and

Whereas, While data is still being compiled for 2019, prelimary results show that 11,500 cases of human trafficking were identified, nearly a 20% increase from 2018;[4,5] and

Whereas, an estimated 50,000 international victims are trafficked into the US yearly;[6] and

Whereas, In 2017 there were 3,126 reported victims in the United States who were legal minors under the age of 18 when their human trafficking began[1]; and

Whereas, In the United States, the current federal anti-trafficking laws are not consistent with state prostitution laws due to differences in age of consent[7]; and

Whereas, Statutory rape laws are not applied consistently when the adult has paid for sex, even if it was with a victim of human trafficking;[8] and

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Whereas, Based on a given state's age of consent, a minor involved in a case of human trafficking could be prosecuted for prostitution, despite being a victim of trafficking into the commercial sex industry[7]; and

Whereas, States' varying restrictions and allowances on age of consent defense allow consumers of child prostitution to evade appropriate sentencing for their crimes while inappropriately punishing victims[9]; and

Whereas, In Ohio, for minors under the age of consent (16), law enforcement officials do not need to prove that the minor was compelled to engage in commercial sexual activity, and the perpetrator of trafficking is charged with a felony of the third degree[10]; and

Whereas, In Ohio, for minors aged 16-17, law enforcement must prove the minor was compelled to engage in commercial sexual activity, and the penalty for the trafficker is a felony of the fifth degree[10]; and

Whereas, Maryland considers the age of consent 16 years, however, juvenile sex trafficking is defined for those under the age 18, but if there is no identified trafficker the juvenile could still be criminalized for prostitution;[11] and

Whereas, In contrast to other state laws, Colorado considers the age of consent 17, however, for the purposes of child trafficking, a "child" is defined as a person below age 18, and trafficking a minor is a class 2 felony, whereas trafficking otherwise is a class 3 felony;[12] and

Whereas, 34 states have Safe Harbor Laws to protect sex trafficking victims from prostitution-related charges but these laws vary greatly by state[13]; and

Whereas, certain Safe Harbor Laws provide full immunity to anyone under 18, others only apply to first-time victims, and others only protect those under a certain age, which was be as low as 14 or 15[13]; and

Whereas, Some states have passed legislation to address the inconsistencies between the age of consent and the exploitation of human trafficking victims, but such laws are limited in scope and vary by state[13]; and

Whereas, Legal discrepancies and variations in interpretation contribute to problems determining the prevalence of child trafficking and may also hinder child trafficking survivors' access to services[14]; and

Whereas, The Department of Justice states that exploitation of a person under 18 for commercial sex is human trafficking, regardless of whether any form of force, fraud, or coercion was used[,2]; and

Whereas, The Trafficking Victims Protection Act of 2000 defines sex trafficking as a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age[2]; and

Whereas, current AMA policy H-60.912 Commercial Exploitation and Human Trafficking of Minors does not address discrepencies between federal and state policy and thus may overlook key issues regarding child trafficking; therefore be it

RESOLVED, Policy H-60.912 Commercial Exploitation and Human Trafficking of Minors be amended as follows:

> **Commerical Exploitation and Human Trafficking of Minors, H-60.912**
>
> 1. Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.
>
> 2. Our AMA collaborate with the state medical societies to support legislation that applies federal definitions and criteria to all cases of human trafficking.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

D-170.992: Human Trafficking / Slavery Awareness

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery. AMA res 015, A-18

H-60.912: Commercial Exploitation and Human Trafficking of Minor

AMA supports the development of laws and policies that utilize public health framework to address commerical sexual exploitation and sex trafficking of minors by promoting care and sercives for victim instead of arrest and prosecution. AMA res 009, A-17

H-65.966: Physicans Response To Victims of Human Trafficking

Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs. AMA res 313, A-15

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H-440.814: Distribution and Display of Human Trafficking Aid Information in Public Places

Our AMA policy is that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings.

Our AMA, through its website or internet presence, will provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same.

Our AMA urges the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings. AMA Res 023, A-19

440.071MSS: Improving the Health and Safety of Consensual Sex Workers

AMA-MSS will ask the AMA to (1) recognize the adverse health outcomes of criminalizing consensual sex work; (2) support legislation that decriminalizes individuals who exchange sex for money or goods; (3) oppose legislation that decriminalizes sex buying and brothel keeping; (4) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors; and (5) support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (MSS Res 05, A-19) (Appended: MSS CGPH Report A, I- 19)

515.008MSS The Identification and Protection of Human Trafficking Victims

The Identification and Protection of Human Trafficking Victims: AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking. (MSS Res 19, A-12) (Reaffirmed: MSS GC Report A, I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 072
(November 2020)

Introduced by: Brenna Kelly, Michael McNamara, Medical College of Wisconsin – Milwaukee, Ryan Wealther, UT Health San Antonio, Anna Heffron, University of Wisconsin School of Medicine and Public Health

Sponsored by: Region 3

Subject: Supporting Sun Safety Education in K-12 Schools

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Each year, more people in the United States (US) are diagnosed with skin cancer than with all other cancers combined,[1] which is estimated to contribute an annual cost of roughly $8.1 billion[2]; and

Whereas, All types of skin cancer are largely a result of excessive UV radiation and sunlight exposure;[3] and

Whereas, Most skin cancers could be prevented if individuals consistently engaged in sun protective behaviors;[4] and

Whereas, While educational efforts on sun safety have been primarily the responsibility of physicians, recent evidence suggests that these methods may be ineffective. Although the USPSTF recommends clinicians counsel fair skinned patients on skin cancer prevention, a recent study found that lack of time is a prevalent barrier to clinical counseling & can limit how much is actually done;[5] and

Whereas, Relying on parents to educate and model appropriate sun safety measures may be insufficient as research suggests that less than 20% of adults effectively role model sun protection measures;[6] and

Whereas, In-school education is an affordable additional option that has been shown to have a positive impact on other preventative health behaviors. For example, most states require in-school health education on nutrition, personal health, physical education and mental/emotional health.[7] This education positively influences health outcomes later in life as risk behaviors decline as years of formal education increase;[8] and

Whereas, Early education has been shown to be effective in establishing and maintaining healthy habits later into life and may be the reason for adopting certain health behavior changes;[9] and

Whereas, One study found that fifth grade students have a lower use of sunscreen compared to adherence to other basic preventative behaviors such as teeth brushing, seatbelt use and wearing a bike helmet;[10] and

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Whereas, Sun education and sun safety practices are of special importance during childhood, as UV exposure during childhood elevates an individual's lifetime risk of developing skin cancer more than exposure in adulthood;[11] and

Whereas, Certain types of melanoma are related to childhood sun exposure;[12] and

Whereas, Despite the fact that several agencies, including the CDC, WHO and The Guide to Community Preventative Services, specifically recommended that schools educate students about sun safety and skin protection,[4,13,14] sun safety education in schools is rare and is declining;[15,4,14] and

Whereas, Sun safety education in schools has resulted in increased knowledge which may lay the foundation for future behavior changes as evidenced by a skin cancer prevention and detection curriculum taught to high schoolers in Florida which resulted in knowledge gains maintained at least six months after classroom teaching;[16] and

Whereas, Knowledge gains are critical given insufficient or inaccurate understanding of the dangers of UV exposure often correlate with a mindset of there being little to no risk. As a result, protecting against the risk often can become irrelevant;[17] and

Whereas, Educational interventions and knowledge gains are associated with a significant increase in reported frequency of sun protection use;[18] and

Whereas, Although it may be difficult for teachers to develop their own sun safety curricula, several free and easy to use sun safety educational programs exist and are fully developed with tools to assist teachers.[19,20] Programs which employ other educators also exist and could reduce burden on teachers without compromising sun education;[21] and

Whereas, The AMA-MSS has policy which encourages elementary schools to develop sun protection policies (60.011MSS), but this policy excludes middle and high school students and does not specifically include education on sun safety; and

Whereas, targeting adolescents is especially important given there is a decline in sun protective behaviors from childhood to adolescence,[22] increased independence from potentially protective parental influence,[17] and increased risk for sun exposure given the greater desire for a tan in adolescent ages;[23] and

Whereas, AMA-MSS and AMA have policies which support educating the public about the long-term effects of sun exposure (440.006MSS) and educational campaigns on the hazards of tanning parlors (H-440.839), but these policies again do not specifically include educational programs in schools, which have a large potential for gains in sun protective behavior; and

Whereas, sun safety education is even more important in the context of the COVID-19 pandemic given individuals are encouraged to spend time outdoors related to quarantine measures and the promotion of socially distanced outdoor activities as a means of wellness without the increased risk of indoor airborne transmission;[24-26] therefore be it

RESOLVED, That our AMA-MSS amend 60.011MSS, "Sun Protection Programs in Elementary Schools," by insertion and deletion:

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60.011MSS. Sun Protection Programs and Education in ~~Elementary~~K-12 Schools: AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage ~~elementary~~ schools to incorporate ~~develop~~ sun protection policies and sun safety education curricula.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation

between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.

Early Detection and Prevention of Skin Cancer H-55.972
1. Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

Permitting Sunscreen in Schools H-440.841
1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization.

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2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

60.011MSS. Sun Protection Programs in Elementary Schools: AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (MSS Res 16, A-04) (Reaffirmed: MSS Res 16, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.044MSS. Sunscreen and Sun Protection Counseling by Physicians: AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sub-protective behavior. (MSS Res 26, I-13)

440.072MSS. Sunscreen Dispensers in Public Spaces as a Public Health Measure: AMA-MSS will ask the AMA to support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (MSS Res 28, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 073
(November 2020)

Introduced by: Anmol Gupta, Baylor College of Medicine; Megan Jiao, McGovern School of Medicine at UTHealth at Houston

Sponsored by: Region 3

Subject: Support for Utility Shut-Off Moratoriums for the Duration of the COVID-19 Pandemic

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Household utility security is critical for families and households to maintain their health[1,2]; and

Whereas, One in three Americans struggle to pay energy bills or sustain adequate heating and cooling in their homes[3]; and

Whereas, Additionally, one in five households report reducing or forgoing necessities such as food and medicine to pay an energy bill[3]; and

Whereas, Furthermore, household utility insecurity disproportionately burdens families that are socially disadvantaged, such as those of low socioeconomic status and racial/ethnic minority households[4]; and

Whereas, For example, households near or below the federal poverty line are more likely to surpass the ten percent threshold on energy expenditures, and African Americans across the economic spectrum experience the highest rates of economic energy insecurity[5]; and

Whereas, Moreover, constant threat of service interruptions contributes to chronic stress and mental health disorders, such as depression and anxiety[4]; and

Whereas, This is compounded by seasonal changes in weather, which can cause and exacerbate a variety of symptoms, especially among those with chronic conditions[6]; and

Whereas, For instance, cold weather can trigger respiratory symptoms and functional disability among people with asthma or allergic rhinitis, and heat stress can trigger cardiovascular issues such as heat strokes, hypertension, and heart attacks, as well as dehydration and hyperthermia[6,7]; and

Whereas, Additionally, approximately 685,000 residents across the United States are dependent upon electrically-powered medical equipment to sustain their lives[8]; and

Whereas, However, given the sharp rise in unemployment due to COVID-19, many families across the United States are unable to pay for their water, gas, heating/cooling, electricity, and internet services and are at risk of having these services shut-off for missed payments[1,9]; and

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Whereas, Due to government mandates, social distancing regulations, and workplace and school policies enacted to prevent COVID-19 spread, families are staying at home more than ever, and their reliance on home utilities has correspondingly increased by 22%[10]; and

Whereas, Early on in the pandemic, dozens of states prohibited utilities from cutting off services in recognition of them as crucial lifelines, and some utility companies promised to forgo shut-offs even in states lacking without legal mandates to do so[11,12]; and

Whereas, However, six months into the pandemic, many state-mandated prohibitions on utility shut-offs are expiring with no indication for renewal, while a majority of states have had no protections at all for this duration of time[9,13]; and

Whereas, The COVID-19 pandemic will likely persist into the fall and winter, and losing critical sources of heat, water, gas, and electricity in homes may be detrimental to the health of entire households[1,]; and

Whereas, Several federal congressional bills introduced in 2020 would establish a national disconnection moratorium, but these bills have yet to pass[2]; and

Whereas, It is predicted that 34.5 million households across 14 states are at risk of losing their utility shutoff protections in the coming month, and 76 million households total are predicted to lack shutoff protections by October[14,15]; therefore be it

RESOLVED, That our AMA supports local, state, and/or national shut-off moratoriums on all life-essential utilities for the duration of the national emergency relating to COVID-19; and be it further

RESOLVED, That our AMA encourages local, state, and federal governments to provide financial assistance, such as with forgivable loans, for utility companies that are compliant with government-sanctioned moratoriums during the national emergency relating to COVID-19.

Fiscal Note: TBD

Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

De-institutionalization of Mental Patients 345.001MSS

1. AMA-MSS will ask the AMA to: (1) support the concept that the de-institutionalization of former psychiatric patients should be accompanied by adequate support from the community in the form of rehabilitation and counseling services; and (2) affirm the basic human rights of patients in board and care facilities to receive proper nutrition, essential medical care, adequate housing, community support, and to be permitted to participate in decisions regarding their environment.

Eradicating Homelessness 440.048MSS

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

Eradicating Homelessness H-160.903

1. Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons; (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs; (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital; (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients; (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative

private space available; and (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

The Mentally Ill Homeless H-160.978

1. (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 074
(November 2020)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine

Sponsored by: Region 2

Subject: Support for Evidence-Based Policy

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Evidence-based policy is policy based on rigorous, objective, replicable research, especially randomized control trials[1,2]; and

Whereas, Using evidence to determine policy leads to the enactment of effective policies and reduces wasteful spending on ineffective policies[1,3-6]; and

Whereas, “Evidence-based” is mentioned in the MSS digest 67 times and has become a core principle of the section, however no general principles guiding the medical student section’s use of evidence in policy making decisions exist; and

Whereas, Internal guidelines on evidence-based policy would allow the MSS caucus to take stronger positions on resolutions and reports that are not sufficiently covered by existing internal policy, but where evidence leads to a clear conclusion; and

Whereas, Without clear internal policy on the topic, the MSS largely remained silent on resolutions related to vaping at the the I-19 meeting, not strongly supporting vaping policy proposals that were based on evidence or recommending referral of proposals backed by insufficient evidence; and

Whereas, Ample evidence of a medicine or clinical algorithm’s effectiveness must be acquired before its application to patient care, and similarly, policies that significantly impact health should be evidence-based[7,8]; therefore be it

RESOLVED, That our AMA-MSS defines evidence-based policy as policy based on rigorous, objective, replicable research, especially randomized control trials; and be it further

RESOLVED, That our AMA-MSS supports policy proposals that are evidence-based and align with our goals as outlined in the MSS Policy Digest; and be it further

RESOLVED, That our AMA-MSS opposes policy proposals that are contradicted by evidence; and be it further

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RESOLVED, That our AMA-MSS, in cases where insufficient evidence exists to indicate a proper course of action, supports studies to acquire the necessary data to make an evidence-based decision; and be it further

RESOLVED, That our AMA-MSS will not allow the process of ensuring evidence-based analysis to interfere with policy decision making in exigent circumstances that can not await further study.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Opposition to Addition of Flavors to Tobacco Products H-495.971
Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco.
CSAPH Rep. 01, A-18; Modified: Res. 916, I-18; Modified: Res. 918, I-19

Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992

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1. Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.
2. Our AMA will: (a) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only; and (b) will advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes. Res. 432, A-18; Appended: Res. 910, I-19

Altering School Days to Alleviate Adolescent Sleep Deprivation 60.022MSS
That our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that the AMA support legislation congruent with those guidelines. (MSS Res 31, A-14) (AMA Res 404, A-15 Referred) (Reaffirmed: MSS GC Rep A, I-19)

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

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

Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S. 150.040MSS
AMA-MSS supports evidence-based methods of addressing food insecurity. (MSS CGPH Report A, A-19)

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care

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professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

Addressing the Need for Firearm Safety in Medical School Curricula 295.209MSS
AMA-MSS will ask the AMA to support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula. (MSS Res. 63, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 075
(November 2020)

Introduced by: Michael Moentmann, Wayne State University School of Medicine; Natasha Sood, Penn State College of Medicine; Michael Franklin, Ashton Lewandowski, Wayne State University School of Medicine; Ruth Osborne, Indiana University School of Medicine; Phillip Yang, University of Michigan School of Medicine.

Sponsored by: Region 5

Subject: Net zero greenhouse gas emissions in the AMA and healthcare sector

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Our AMA has substantial policy recognizing the impacts of climate change, committing to sustainable business operations, emphasizing the importance of physician leadership regarding climate change, and encouraging other stakeholders in healthcare to practice environmental responsibility, but has no explicit emissions goal and no way to account for progress towards environmental sustainability (H-135.938, H-135.923, G-630.100, H-135.973); and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world[1,2]; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with $14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009[3,4]; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions[5]; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100[5]; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100[3,4]; and

Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require “global net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by 2030, and reach net zero by approximately 2050”[5]; and

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Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific time period[3]; and

Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-profit organizations, large corporations, and countries have committed to carbon neutrality for their business operations by a date certain in order to improve their business efficiencies and to foster the development of carbon neutral practices[7,8,9]; and

Whereas, Other organizations in the healthcare industry have committed to becoming carbon neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all University of California campus and medical centers, the Cleveland Clinic, and Kaiser-Permanante[10,11,12,13]; and

Whereas, Other professional organizations, including the Association of Energy Services Professionals, and International Federation of Medical Students' Associations have committed to making their conferences carbon neutral[14,15,]; and,

Whereas, Our AMA has set discrete benchmark dates for achieving goals in other settings, including child blood lead levels (H-60.924), accreditation of health care service providers in jails (D-430.997), and disaggregation of demographic data (H-350.954); therefore be it

RESOLVED, That our AMA will commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization; and be it further

RESOLVED, That our AMA create educational programs for and encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization; and be it further

RESOLVED, That our AMA will report the progress on implementing this resolution at each Annual Meeting hereafter.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Toward Environmental Responsibility 135.012MSS
AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

Statement of Sustainability Principles 135.013MSS
AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives

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such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15)

Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability 135.014MSS

AMA-MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows:

> Support of Clean Air and Reduction in Power Plant Emissions H-135.949
>
> Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

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

Global Climate Change and Human Health H-135.938:
Our AMA:
(1) Supports the findings of the Intergovernmental Panel on Climate Change's **fourth assessment report** and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
(2) Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
(3) (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
(4) Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
(5) Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
(6) Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08) (Reaffirmation A-14) (Reaffirmed: CSAPH Rep. 04, A-19) (Reaffirmation: I-19)

Global Climate Change - The "Greenhouse Effect" H-135.977:

Our AMA
(1) Endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) Urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) Endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) Encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) Encourages humanitarian measures to limit the burgeoning increase in world population.
(CSA Rep. E, A-89) (Reaffirmed: Sunset Report, A-00) (Reaffirmed: CSAPH Rep. 1, A-10) (Reaffirmation A-12) (Reaffirmed in lieu of Res. 408, A-14)

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA:
(1) Supports initiatives to promote environmental sustainability and other efforts to halt global climate change;
(2) Will incorporate principles of environmental sustainability within its business operations; and
(3) Supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
(Res. 924, I-16) (Reaffirmation: I-19)

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

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(15) Will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS);
(16) Encourages expanded funding for environmental research by the federal government; and
(17) Encourages family planning through national and international support.
(CSA Rep. G, I-89) (Amended: CLRPD Rep. D, I-92) (Amended: CSA Rep. 8, A-03) (Reaffirmed in lieu **of** Res. 417, A-04) (Reaffirmed in lieu **of** Res. 402, A-10) (Reaffirmation I-16)

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
(1) Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
(2) Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
(BOT Rep. 34, A-18)

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
Our AMA supports:
(1) Federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and
(2) Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels
(Res. 429, A-03) (Reaffirmation I-07) (Reaffirmed in lieu of Res. 526, A-12) (Reaffirmed: Res. 421, A-14) (Modified: Res. 506, A-15) (Modified: Res. 908, I-17)

EPA and Greenhouse Gas Regulation H-135.934
(1) Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control greenhouse gas emissions in the United States.
(2) Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
(Res. 925, I-10) (Reaffirmed in lieu of Res. 526, A-12) (Reaffirmed: Res. 421, A-14) (Appended: Res. 523, A-17)

Conservation, Recycling, and Other "Green" Initiatives G-630.100
AMA policy on conservation and recycling include the following:
(1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives.
(2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such.
(3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.
(CCB/CLRPD Rep. 3, A-12) (Modified: Speakers Rep., A-15)

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

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(1) Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
(2) Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
(Res. 001, I-17) (Appended: Res. 403, A-19)

Reducing Lead Poisoning H-60.924

(1) Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
(2) Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
(3) Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to

mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).
(4) Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
(CCB/CLRPD Rep. 3, A-14) (Appended: Res. 926, I-16) (Appended: Res. 412, A-17)

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
(Res. 440, A-04) (Amended: BOT Action in response to referred for decision Res. 602, A-00) (Reaffirmation I-09) (Reaffirmation A-11) (Reaffirmed: CSAPH Rep. 08, A-16) (Reaffirmed: CMS Rep, 02, I-16) (Appended: Res. 421, A-19) (Appended: Res. 426, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 076
(November 2020)

Introduced by: Ellena Popova, University of Pennsylvania; Rohan Khazanchi, University of Nebraska Medical Center; Ryan Nowrouzi, Anmol Gupta, Baylor College of Medicine; Winnie Rao, Drexel University College of Medicine; Jara Crawford, Indiana University

Sponsored by: Association of Native American Medical Students

Subject: Federal Health Insurance Funding for People Experiencing Incarceration

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The United States incarcerates more people (2.2 million) at a starkly higher rate (700 per 100,000) than any other country in the world, partially driven by federal mandatory minimum sentencing for drug-related offenses and the deinstitutionalization of people with mental illnesses[1-4]; and

Whereas, Incarceration in the U.S. disproportionately impacts communities of color--nearly one in three Black men will be imprisoned in their lifetime, and nearly half of Black women currently have a family member in prison[4]; and

Whereas, A history of incarceration significantly increases the risk of chronic medical conditions affecting all major organ systems, even after adjusting for sociodemographic factors, tobacco and alcohol use, and adverse childhood and life events[5]; and

Whereas, The Social Security Act currently prohibits the use of federal services such as Medicaid for inmates in jails and prisons, meaning these services are suspended or terminated for the duration of incarceration[1]; and

Whereas, This interruption in insurance coverage adds to the difficulty of post-release transitions of care, on top of other existing barriers such as stigma and discrimination, cost, and difficulty understanding healthcare coverage[6,7]; and

Whereas, A prominent study in the *New England Journal of Medicine* revealed that within the first two weeks of release from prison, former inmates have a 13-times greater risk of death compared to other state residents, with a 129-times greater risk of death from drug overdose in particular[8]; and

Whereas, Post-release care is vitally important in reducing mortality risk within the first two weeks, as well as in managing chronic medical conditions like HIV, diabetes, substance use disorders, mental illness, cancer, and more[5,9-13]; and

Whereas, Recently incarcerated individuals who are enrolled in Medicaid at time of release are more likely to access and receive community services, have fewer repeat detentions, and greater time between detentions[14,15]; and

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Whereas, Permitting the use of federal services during incarceration could further reduce coverage gaps, minimize the administrative burden associated with suspension/termination, and improve health outcomes[16-19]; and

Whereas, There is significant heterogeneity in the quality and quantity of care available to people who are incarcerated, partially due to the lack of enforced universal basic standards of care[16,20]; and

Whereas, Only a minority of US correctional institutions have chosen to undergo the opt-in, voluntary accreditation process of of the National Commission on Correctional Health Care Standards, thus, the main method of enforcing a minimum standard for healthcare provision has been through litigation[21,22]; and

Whereas, Our AMA encourages adoption of national standards to help ensure quality, equitable healthcare for all incarcerated patients (D-430.997); and

Whereas, If federal services are made available during incarceration, jails and prisons requesting federal reimbursement would be required to meet appropriate national standards for minimum care pursuant to the Social Security Act[16,22,23]; and

Whereas, As it stands, institutions are perversely incentivized to save money by sacrificing high-quality and preventative care, which harms incarcerated patients through methods including minimizing hired staff, charging copays, intentionally limiting access to care, not offering Hepatitis C or HIV screenings, or failing to provide evidence-based treatment for Hepatitis C and substance use disorders[16,21,24-31]; and

Whereas, In 2017, between jails and prisons, over 10.5 million people were released from incarceration, exposing their communities to the significant infectious disease burden found in these facilities, including a Hepatitis C rate of 8-21 times higher and tuberculosis rate of more than 4 times higher than that of the general population[32-36]; and

Whereas, An estimated 57% of individuals released from prison are either Medicaid-eligible or eligible for federal tax credits under the Affordable Care Act, so disease complications and transmission due to lapses in access to care during and immediately following incarceration incur significant costs to the federal government[37,38]; and

Whereas, During the COVID-19 pandemic, Illinois, South Carolina, and California submitted Section 1115 waivers asking to waive the Medicaid inmate exclusion for COVID-19 testing and treatment, with Illinois citing that public health benefits will exceed costs[22,39-41]; and

Whereas, Permitting the use of federal funding to match inmate health expenses would help states maintain a balanced budget while adequately addressing inmate health needs, as evidenced by estimated annual savings of up to $4.7 billion if Medicaid expansion states are able to cost-share their corrections budgets[42-44]; and

Whereas, In 2016, 65% of the 10.6 million people admitted to local jails were presumed innocent and awaiting trial, signifying that the suspension of federal benefits disproportionately impacts those who cannot afford to post bail in spite of their presumed innocence[45]; and

Whereas, As of February, 2020, these presumed innocent individuals are still being stripped of their federal benefits during this holding period despite the advocacy of the National Association

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of Counties and National Sheriffs Association, leading to high costs and significant interruptions in care[45-47]; therefore be it

RESOLVED, That our AMA advocate for the continuation of federal health insurance benefits, such as Medicaid, for otherwise eligible individuals who are detained prior to trial, until they receive a final guilty verdict; and be it further

RESOLVED, That our AMA advocate for the continuation of federal health insurance benefits, such as Medicaid, for otherwise eligible individuals throughout the entire duration of their incarceration.

Fiscal Note: TBD

Date Received: 09/20/2020

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47. Restoring Health Benefits for Justice-Involved Individuals, S.2626 (10/17/2019).

RELEVANT AMA AND AMA-MSS POLICY

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

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(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.
(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.
(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.
CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile

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facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

650.033MSS Co-payments in Prisons
AMA-MSS will ask the AMA to advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities. *(MSS Res. 04, I-19)*

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 077
(November 2020)

Introduced by: Alex Butler, Columbia University Vagelos College of Physicians & Surgeons; Amrit Vasdev, University of Minnesota-Twin Cities; Reha Rabbani, Northeast Ohio Medical University; Nicole Lee, Western Michigan University; Richard Saporito, Rutgers New Jersey Medical School; Jacob Radparvar, Tufts University School of Medicine; Matthew Van De Graaf, Eastern Virginia Medical School; Samuel Roberts, Midwestern University College of Osteopathic Medicine; Josh Bilello, University of Texas Medical Branch; Shyon Parsa, University of Texas Southwestern; Olivia Henry, Vanderbilt University Medical School

Sponsored by: N/A

Subject: Increased Utilization of Point-of-Care Medical Tools in Undergraduate Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Overall medical knowledge will double every 73 days in 2020[1] and studies have shown that in Primary Care alone, 7,287 articles are published monthly in 341 active journals, requiring physicians to take nearly 628 hours per month to evaluate them fully[2]; and

Whereas, Less time is available for physicians to stay up-to-date on current medical knowledge[3]; and

Whereas, Lack of up-to-date information can lead to improper management and inappropriate patient care[4], and that use of electronic knowledge resources is associated with a positive impact on clinician behaviors and patient effects[5]; and

Whereas, Point-of-care (POC) tools are defined as “a resource with immediate access to filtered summaries providing current recommendations for the management of medical problems”[6] such as MedScape, UpToDate, DynaMed, EvidencePlus, and Epocrates; and

Whereas, The majority of medical residents report using medical POC tools, including but not limited to UpToDate and Google Scholar, at least daily[7];

Whereas, Provider use of UpToDate has been associated with reduced length of stay, lower risk-adjusted mortality rates, and better quality clinical performance[8] as well as increased appropriateness of diagnoses and treatment decisions, and improved drug knowledge and understanding[9,10]; and

Whereas, When used as POC clinical decision support systems, mobile devices have been found to improve completeness and accuracy of patient documentation, produce more accurate diagnostic coding, and lead to more frequent documentation of side effects[11,12]; and

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Whereas, Medical students often rely on POC tools including PubMed and UpToDate when answering clinical questions[13]; and

Whereas, Insufficient time in curriculum, perceived lack of importance compared to traditional curriculum of basic science or clinical courses, and difficulty integrating with clinical care were the most significant barriers to effective use of POC resources in undergraduate medical education[14]; and

Whereas, Lack of awareness and relevant experience may keep medical trainees from using reliable and appropriate resources that have undergone rigorous review and evaluation[15,16]; and

Whereas, Self-guided inquiries into these resources without proper training or exposure are frequently incomplete and can lead to improper use of these resources[17]; and

Whereas, Removal of barriers has been shown to lead to high uptake of POC tools by medical students with continued usage after graduation as well as decreased usage of non-validated online resources such as Wikipedia[18]; and

Whereas, Current AMA policy D-480.972 supports “uniform regulation for use of mobile devices in medical education and clinical training”[19]; and

Whereas, Current AMA policy H-460.908 recommends the development of “educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications”[20] but does not include exposure to or training in general point-of-care tools; therefore be it

RESOLVED, That our AMA-MSS support education of physicians-in-training on proper utilization of medical POC electronic knowledge resources in clinical practice.

Fiscal Note: TBD

Date Received: 09/20/2020

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19. AMA Policy D-480.972: Res. 903, I-19.
20. AMA Policy H-460.908” Joint CMS/CSAPH Rep. 01, I-17.

RELEVANT AMA AND AMA-MSS POLICY

Augmented Intelligence in Medical Education H-295.857

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Our AMA encourages: (1) encourages accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies; (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies; (9) institutional leaders and academic deans to proactively accelerate the inclusion of non clinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and (10) close collaboration with and oversight by practicing physicians in the development of AI applications. CME Rep. 04, A-19.

Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations. Modified: Res. 903, I-19.

Genomic-Based Personalized Medicine D-460.908

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Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information. Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17.

Clinical Information Technology Assistance D-478.990
Our AMA will seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors. Reaffirmation A-10.

Integrating Precision Medicine into Alternative Payment Methods H-185.923
Our AMA: (1) affirms that clinical pathways should be developed by clinical experts, including national medical specialty societies, and should be leveraged by or integrated into electronic health records for decision support, seamless documentation, and automation of communication with payers for authorization; (2) encourages alternative payment models (APMs) to incorporate evidence-based clinical pathways as appropriate and as recommended by national medical specialty societies; (3) supports transparent and accessible rapid learning systems with the ability to extract clinically meaningful information and use it to modify clinical practice guidelines and pathways in real-time; (4) supports assessment within new payment and delivery models of the value of evidence-based precision medicine tests and therapeutics to patients, families and the health care system, including the impact on patient experience, disease progression, quality of life and survival; (5) encourages APMs to integrate precision medicine approaches, where appropriate, to improve the diagnostic process and personalize patient care; and (6) encourages APMs to measure patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value. CMS Rep. 06, A-18.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 078
(November 2020)

Introduced by: Ida Vaziri, Cameron Holguin, Connor Byrne, University of Texas Health at San Antonio Long School of Medicine

Sponsored by: Region 3

Subject: Banning LGBTQ+ "Panic" Defenses

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In the United States, the adult LGBTQ+ community is estimated to be 4.5 percent of our population, or approximately 14.6 million people[1]; and

Whereas, FBI hate crime statistics show that LGBTQ+ people are disproportionately targeted in committed criminal offenses because of their identity[2]; and

Whereas, Data from the 2003–2013 National Crime Victimization Survey (NCVS) shows that 1 out of 5 lesbian, gay, and bisexual people and 1 out of 4 transgender people living in the United States will experience a hate crime in their lifetime[3]; and

Whereas, The LGBTQ+ "panic" defense is a legal strategy that blames a victim's sexual orientation or gender expression as the cause of the defendant's violent behavior, which can range from assault to murder[4]; and

Whereas, When a perpetrator uses an LGBTQ+ "panic" defense, they are claiming that a victim's sexual orientation or gender identity explains and excuses a loss of self-control and the subsequent assault[4]; and

Whereas, This legal strategy has been successfully used to reduce sentences and even acquit defendants[4]; and

Whereas, A study of 104 murder trials between 1970 and 2020 found that the use of the LGBTQ+ "panic" defense led to reduced charges in nearly 33% of the cases[5];and

Whereas, In 2013, Islan Nettles, a 21-year-old transgender woman, was beaten and murdered on a street in Harlem, New York after the assailant flirted with her and realized that she was transgender[6]; and

Whereas, The defense team used the LGBTQ+ "panic" defense to justify why the assailant, James Dixon, reacted in such a violent way. Dixon was only sentenced to 12 years in prison for manslaughter; a charge lighter than murder or homicide[6]; and

Whereas, In 2015, James Miller stabbed Daniel Spencer twice, killing him. In court, Miller justified his actions by claiming that he believed that Spencer was making a sexual pass at him[5,7]; and

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Whereas, The jury convicted Miller of criminally negligent homicide, the lowest grade of felony in Texas. Ultimately, the court punished Miller with only a six-month jail term and a 10-year probation sentence[5,7]; and

Whereas, A study asked 352 jury-eligible citizens to read vignettes depicting a control, gay panic as provocation, or gay panic as insanity condition and provide verdicts and ratings of blame and responsibility[8]; and

Whereas, Researchers found an observed leniency effect when gay panic was claimed in either context[8]; and

Whereas, 11 states have explicitly banned the use of LGBTQ+ “panic” defenses in court and other states have introduced legislation against it[4]; and

Whereas, AMA policy H-65.965 (Support of Human Rights and Freedom) recognizes that hate crimes pose a significant threat to the health and welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation, and registers support for hate crimes prevention legislation; therefore be it

RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ “panic” defenses in court in order to protect LGBTQ+ victims of sexual violence.

Fiscal Note: TBD

Date Received: 09/13/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support of Human Rights and Freedom H65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14 Reaffirmed in lieu of: Res. 001, I-16 Reaffirmation: A-17

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

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

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understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity. CSA Rep. C, I-81, Res. 16, A-18, Reaffirmed: CSAPH Rep. 01, I-18

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience. Res. 008, A-19

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. Res. 402, A-12

References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment G-600.067
Our AMA will: (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; (3) present the preliminary study results to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and (4) produce a report within 18 months with study results and recommendations. Res. 009, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 079
(November 2020)

Introduced by: Amanda Myles, Shefali Jain, Gregory Patterson, Aparna Kanjhlia, Kalyani Ballur; Medical College of Georgia at Augusta University

Sponsored by: N/A

Subject: Advocating for Mental Health and Wellbeing Clinical Protocols at the State and Federal Levels for Patients in Long-Term Care Facilities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Long-term care encompasses elderly patients in board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities[1]; and

Whereas, While only 10% of community-dwelling Americans age 65 and older report experiencing severe loneliness, the rates are at least double, between 22% and 42%, for residents in care homes[2]; and

Whereas, Loneliness and social isolation in institutionalized people such as residents in long-term care facilities is "at least as important as helping them with personal hygiene,"[3] as social isolation in elderly adults increases health risks such as weakened immune system, high blood pressure, heart disease, cognitive decline, and death[4, 5, 6]; and

Whereas, Adults with multimorbidity, polypharmacy, and frailty,[7] as with those in long-term care facilities, are those at high risk for morbidity and mortality with COVID-19; and

Whereas, Long-term care facilities represent <1% of the total US population, yet they account for greater than 40% of COVID-19 deaths in the US[8]; and

Whereas, The COVID-19 national health crisis shows the direct impact of social isolation on health status, highlighting a lack of any policy for the mental health and wellbeing of long-term care patients; and

Whereas, At a state-level, successful interventions like the "Buddy Calls" program have been implemented by medical students in Athens, GA to ease feelings of social isolation in the elderly[9]; and

Whereas, Cigna and SCAN Health Plan have implemented pilot programs to target social determinants of health needs by increasing funding for community partnerships and eliminating telehealth cost-sharing for seniors affected by coronavirus, these are temporary and only limited to eligible Medical Advantage customers[10]; and

Whereas, The current American Medical Association (AMA) and Medical Student Section (MSS) policies align in being patient-centered as they strive to achieve better quality of care for all patients in long-term care facilities; and

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Whereas, Current policy recommends the “development of standards which improve patient safety ... to effect an update of good health care policy,” the policy but does not specify the long-term care population and it does not extend beyond the focus of patient safety; and

Whereas, Current policy “encourages research into the needs of dying patients and how the care system could better serve them”- this policy focuses on the research aspect of care rather than an effective generation of clinical mental health and wellbeing protocols based on action and also does not encompass all long-term care patients; therefore be it

RESOLVED, That our AMA advocate for expanded mental health and wellbeing programs targeting social isolation and loneliness for the residents of long-term care facilities when in-person interaction is not available or advised; and it be further

RESOLVED, That our AMA supports efforts to increase awareness and education on social isolation and its impact on emotional and physical health, especially in the senior population; and it be further

RESOLVED, That our AMA studies the use of audio-visual services utilized in telemedicine services to combat social isolation and loneliness in patients who cannot be with others in person due to convenience matters or safety concerns.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

List Relevant AMA Policy

Good Palliative Care H-70.915
Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them. CCB/CLRPD Rep. 3, A-14, Reaffirmed: BOT Rep. 05, I-16, Reaffirmed: Res. 119, A-18

Palliative Care and End-of-Life Care H-295.875
Our AMA:
1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.
4. Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics. BOT Rep. 5, A-06Appended: Res. 322, A-14Reaffirmed: BOT Rep. 05, I-16

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Hospice Care H-85.955
Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital. CCB/CLRPD Rep. 3, A-14Reaffirmed: BOT Rep. 05, I-16Appended: Res. 212, A-19

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly. CMS Rep. 04, I-16Reaffirmed: Res. 119, A-18

Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
Our AMA adopts the following principles for the development and application of utilization management guidelines:
(1) The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate.
(2) These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.
(3) Appropriate data, clinical evidence, and review criteria shall be available on request
(4) When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular

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health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.
(5) Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines.
(6) The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.
(7) Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.
BOT Rep. 6, A-99Reaffirmed: Res. 820, A-00Reaffirmed: CSAPH Rep. 1, A-10Reaffirmed: Res. 708, A-16Reaffirmed: CMS Rep. 08, A-17

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

CSA Rep. D, I-92Reaffirmed by CME Rep. 5, I-95Reaffirmed and Modified: CSA Rep. 8, A-05Reaffirmed: BOT Rep. 8, I-06Reaffirmed: CSAPH Rep. 01, A-16

Update on Patient Safety H-450.949
Our AMA: (1) asserts that quality improvement programs must always consider patient safety when selecting their objectives; and (2) encourages all physicians to become familiar with and capitalize on opportunities to use technology to ensure patient safety in prescribing medications and medical devices.

BOT Rep. 13, I-00Reaffirmed: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 01, A-20

Support of Patient Safety Aspects of The Joint Commission D-450.987
Our AMA will continue to work with The Joint Commission on the development of standards which improve patient safety; and our AMA and The Joint Commission will then present these changes to the Centers for Medicare & Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy.

Res. 530, A-04Modified: CMS Rep. 1, A-14

Promoting Patient Safety E-8.6
In the context of health care, an error is an unintended act or omission or a flawed system or plan that harms or has the potential to harm a patient. Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician's honesty with the patient.

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Even when new information regarding the medical error will not alter the patient's medical treatment or therapeutic options, individual physicians who have been involved in a (possible) medical error should:
(a) Disclose the occurrence of the error, explain the nature of the (potential) harm, and provide the information needed to enable the patient to make informed decisions about future medical care.
(b) Acknowledge the error and express professional and compassionate concern toward patients who have been harmed in the context of health care.
(c) Explain efforts that are being taken to prevent similar occurrences in the future.
(d) Provide for continuity of care to patients who have been harmed during the course of care, including facilitating transfer of care when a patient has lost trust in the physician.
Physicians who have discerned that another health care professional (may have) erred in caring for a patient should:
(e) Encourage the individual to disclose.
(f) Report impaired or incompetent colleagues in keeping with ethics guidance.
As professionals uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing medical errors. Both as individuals and collectively as a profession, physicians should:
(g) Support a positive culture of patient safety, including compassion for peers who have been involved in a medical error.
(h) Enhance patient safety by studying the circumstances surrounding medical error. A legally protected review process is essential for reducing health care errors and preventing patient harm.
(i) Establish and participate fully in effective, confidential, protected mechanisms for reporting medical errors.
(j) Participate in developing means for objective review and analysis of medical errors.
(k) Ensure that investigation of root causes and analysis of error leads to measures to prevent future occurrences and that these measures are conveyed to relevant stakeholders.
AMA Principles of Medical Ethics: I,II,III,IV,VIII
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

List Relevant AMA-MSS Policy

Quality of Nursing Homes 280.001MSS
Quality of Nursing Homes: AMA-MSS will ask the AMA to express publicly its concern for inadequate nursing home care, advocate high standards for such care, and support efforts to establish adequate funding of nursing and convalescent homes that would allow them to maintain qualified personnel. (AMA Res 161, A-79 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 080
(November 2020)

Introduced by: Justin T. White, University of Louisville School of Medicine; Shyon Parsa, University of Texas Southwestern Medical School

Sponsored by: Region 5

Subject: Education in Communicating with and Providing Services to Individuals with Communication Disorders

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Communication is recognized as a fundamental human right in the United Nations Universal Declaration of Human Rights[1]; and

Whereas, Communication disorders are defined as "impairment(s) in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems … and may be evident in the processes of hearing, language, and/or speech"[2];

Whereas, Communication disorders may be developmental or acquired[2] and affect 5-10% of the American population[3,4]; and

Whereas, Individuals with communication disorders can experience communication limitations due to medical interventions (such as tracheostomy, respiratory ventilation, surgery to speech structures) or recent-onset dysarthria and/or aphasia, resulting from medical conditions (such as cortical strokes, brainstem strokes, traumatic brain injury)[5]; and

Whereas, Adults with communication disorders have been shown to have greater difficulty accessing healthcare than those without a communication disorder and often delay or forego care due to cost and availability[6]; and

Whereas, Individuals with communication disorders have more chronic conditions than those without a communication disorder[6] and are at a higher risk for experiencing preventable adverse events in acute care settings[7]; and

Whereas, Adults with communication disorders seldom receive quality emergency and routine care[6] and patients with disabilities, including communication disorders, have faced significant barriers when communicating with healthcare providers[8-10]; and

Whereas, Physicians treat individuals with communication disorders across the lifespan and communication with patients plays a critical role in the delivery and fidelity of care[11]; and

Whereas, The AMA's Code of Ethics Opinion 8.5 says that physicians have a professional obligation to "cultivate effective communication and trust by seeking to better understand factors

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that can influence patients' health care decisions, such as … language or other barriers to communication"[12]; and

Whereas, Physicians have reported a lack of formal training in communicating with individuals with communication disorders and have felt that their lack of skills negatively impacted their practice[13]; and

Whereas, Communication breakdowns during medical encounters negatively affected the relationship between physicians, patients with communication disorders, and their families[13]; and

Whereas, Communication training programs for providers have been shown to improve their comfort and willingness to modify their communication when treating individuals who have communication disorders while improving provider knowledge and improving patient quality of life[14-24]; and

Whereas, The AMA recognizes that interprofessional education is a priority of the American medical education system and supports the preparation of medical students to practice in "physician-led interprofessional teams"[25]; and

Whereas, Speech-language pathologists "work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults,"[26] and audiologists are "healthcare professionals who provide patient-centered care in the prevention, identification, diagnosis, and evidence-based treatment of hearing, balance, and other auditory disorders for people of all ages"[27]; and

Whereas, Interdisciplinary care models have been shown to improve patient outcomes and reduce revenue loss[28-30], including improving the likelihood that patients will complete their plan of care; and

Whereas, Federal Medicaid regulations require that patients receive referrals for audiology or speech-language pathology services "by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law"[31];

Whereas, The AAMC's survey of 52,076 graduating medical students found that speech-language pathologists and audiologists were not well-represented in interprofessional education interactions, with less than 4.7% of students reporting interactions with these professions[32], highlighting the lack of education about these rehabilitative services; therefore be it

RESOLVED, That our AMA-MSS amend Resolution 295.186MSS by insertion of the following:

295.186MSS Addressing Communication Deficits in Medical School Curricula

1. AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.
2. <u>AMA-MSS supports medical student training that emphasizes the unique communication needs of individuals with communication disorders.</u>

;and be it further

RESOLVED, Our AMA-MSS promotes and develops medical student education that addresses the role and utility of rehabilitative healthcare providers in the treatment of individuals with

communication disorders, including, but not limited to, speech-language pathologists and audiologists.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Treatment of Persons with Hearing Disorders H-35.967
1. Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibratory disorders.

2. Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders.

3. Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.
CCB/CLRPD Rep. 3, A-14

Health Literacy H-160.931
Our AMA:
(1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
(7) encourages the allocation of federal and private funds for research on health literacy;

(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.
CSA Rep. 1, A-98 Appended: Res. 415, I-99 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Appended: Res. 718, A-13

Children and Youth with Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.
CSA Rep. J, I-91Modified: Sunset Report, I-01Modified: CSAPH Rep. 1, A-11

Training in Sign Language 295.002MSS
AMA-MSS endorses the concept of training physicians in total communication with the deaf and encourages utilization of existing programs in sign language and total communications with the deaf. *(MSS Sub Res 18, A-82) (Reaffirmed: MSS COLRP Rep B, I95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I10) (Reaffirmed: MSS GC Rep D, I-15)*

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

Increasing Education Regarding Transition Planning for Children with Chronic Health Conditions, Not Limited to Those with Developmental Disabilities
The MSS formally establishes support for the following HOD policy:
Children and Youth with Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the

various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. (CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)
(MSS Res 52, I-18)

Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools.

2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.

3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.

4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.

5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
(Res. 308, A-08, Appended: CME Rep. 1, I-12)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 081
(November 2020)

Introduced by: Yianni Bakaes, University of South Carolina School of Medicine Columbia; Tristan Mackey, University of South Carolina School of Medicine Greenville

Sponsored by: N/A

Subject: Ensuring access to child mental health services and child abuse reporting during increased stress and risk

Referred to: MSS Reference Committee (Sarah Mae Smith, Chair)

Whereas, Child protective service agencies across the US received 4.3 million reports alleging abuse and neglect of 7.8 million children in 2018 alone according to the U.S. Department of Health and Human Services, nearly 678,000 of which were determined to be confirmed victims[1]; and

Whereas, In the United States, 67% of substantiated child abuse or neglect reports come from victim-serving professionals[2]; and

Whereas, Teachers, administrators, school counselors, and other educational professors report one in every five child-mistreatment claims in the nation, according to the U.S. Department of Health and Human Services. Family members collectively represent only 12% of hotline calls[1]; and

Whereas, Texas Department of Family Protective Services data shows that in Texas, where the law requires anyone who suspects child abuse to notify authorities, teachers are the single largest group of reporters; the state's abuse hotline received 297,411 reports of suspected child abuse in fiscal year 2019 and 66,737 of them came from teachers[1]; and

Whereas, Though necessary to slow the spread of COVID-19, actions such as social-distancing, sheltering in-place, restricted travel, and closures of key community foundations are likely to dramatically increase the risk for family violence around the globe[3]; and

Whereas, Among the measures intended to reduce the spread of the virus, most schools closed, canceled classes, and moved it to home-based or online learning to encourage and adhere to social distancing guidelines[4]; and

Whereas, Social distancing coupled with increased economic stress in vulnerable households increases risk for domestic violence and child abuse and neglect[5]; and

Whereas, Controlling behaviors (often a means of coping with trauma), unemployment, and limited access to social support systems have all been identified as family violence risk factors that also commonly occur after natural disasters[6]; and

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Whereas, Children reside in 60% or more of households where domestic violence is perpetrated and are also at risk of suffering significant physical and/or emotional harm[7]; and

Whereas, According to data from 2018, in substantiated child abuse cases, 78% of children were victimized by a parent[8]; and

Whereas, State agencies tasked with investigating complaints and keeping kids safe have scaled back services to slow the spread of the pandemic[1]; and

Whereas, In Florida, some child protection groups have turned to virtual home visits instead of in-person check-ins[1]; and

Whereas, Child protection agencies are experiencing strained resources with fewer workers available, making them unable to conduct home visits in areas with stay-at-home orders[9]; and

Whereas, Childhelp playrooms, where volunteers provide direct support and supervision to children who have been abused, neglected, or traumatized, have been closed to prevent the spread of COVID-19, with forensic interviews occurring less often[10]; and

Whereas, According to the National Children's Alliance in regards to child abuse reporting, national children's advocacy centers, which provide support for families and children as abuse cases move through the justice system, reported serving 40,000 fewer children nationwide between January and June of this year than the same period last year, a 21% drop[11]; and

Whereas, Many child welfare organizations are noting a significant drop in reports of child abuse or neglect, which may be a result of fewer opportunities for detection as opposed to an actual decrease in incidence[3]; and

Whereas, Since the pandemic began, there have been isolated reports of increased child abuse severity, however numerous states are reporting an ominous decrease in reports to child protective services (CPS), thought to be related to under-recognition[12]; and

Whereas, As the Childhelp National Child Abuse Hotline and chatline are invaluable resources for children stuck at home with abusers, increased workforce has been implemented and more support has been added with the help of remote onboarding processes[10]; and

Whereas, In July, calls, texts, and chats to the Childhelp National Child Abuse Hotline were up 27% compared with July of 2019. In June, calls, texts, and chats were up 32% compared with the same month last year[11]; and

Whereas, Children are a vulnerable group in this global public health emergency, as their nervous systems, endocrine systems, and hypothalamic-pituitary-adrenal axes are not well developed[13]; and

Whereas, Psychological crises often cause children to produce feelings of abandonment, despair, incapacity, and exhaustion, and even raise the risk of suicide[13]; and

Whereas, COVID-19-associated mental health risks will disproportionately hit children and adolescents who are already disadvantaged and marginalized, especially since isolation, contact restrictions and economic shutdown impose a complete change to the psychosocial environment of affected countries[14]; and

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Whereas, To improve health care access for children, action is needed to address the physical and mental health effects of the COVID-19 crisis among children and offset the potential for widening health disparities among those in poverty[15], and

Whereas, When Covid-19 related measures are lifted and society returns to "normal", child abuse victim-serving professionals may find themselves completely buried in reports and unable to meet the needs of an overwhelming number of victims[3]; and

Whereas, As of September 17, 74% of the 100 largest school districts have chosen remote learning only as their back-to-school instructional model, affecting over 9 million students, which means that virtual resources can be an effective mechanism to reach students in their homes[16]; therefore, be it

RESOLVED, That our AMA will collaborate with state and other relevant medical societies to increase public knowledge and awareness about available virtual child abuse and mental health resources for the pediatric population during times of increased stress and risk, such as a pandemic; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Identifying and Reporting Suspected Child Abuse H-515.960
(1)Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.

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(2)Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
(3)Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
(4)Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
(5)Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
(6)Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
(7)Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
(8)Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.
CSAPH Rep. 2, I-09; Appended: Res. 411, A-18

Child Protection Legislation H-60.948
The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes.
Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07; Reaffirmed: BOT Rep. 22, A-17

Family and Intimate Partner Violence H-515.965
1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for

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incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation

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mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 082
(November 2020)

Introduced by: Calvin Schaffer, Paula Whitmire, University of Massachusetts Medical School; Kumail Hussain, The Chicago Medical School; Abigail Rentschler, Michigan State University College of Human Medicine; Yvonne Lei, UCLA David Geffen School of Medicine; Christopher Wong, Baylor College of Medicine; Majd Aboona, University of Arizona College of Medicine-Phoenix; Steven Graefe, Jenna Heil, Creighton University School of Medicine; Abigail Wen-Yu Cheng, Western Michigan University Homer Stryker M.D. School of Medicine

Sponsored by: Region 1, Region 3, Region 4, Region 5

Subject: Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, having limited access to healthy and affordable food is recognized as a social determinant of health and disproportionately affects people in particular socioeconomic, racial, and ethnic groups, contributing to existing health disparities[1]; and

Whereas, according to the 2020 United States Department of Agriculture Economic Research Service, 35% of low-income households struggle with food security according to 2018 data[2]; and

Whereas, more than 13 million US children lived in food-insecure households, which are described as homes where they lacked access to sufficient food to support a healthy and active lifestyle, and rates of food insecurity are twice as high among Black and Hispanic households compared to White households[3-4]; and

Whereas, food insecurity across a child's first 5 years of life is associated with poorer outcomes on a range of family well-being indicators, lower levels of mental health, and higher levels of family conflict[3]; and

Whereas, food insecurity showed that adults aged 20-39 had higher odds of having prediabetes/diabetes due to greater consumption of carbohydrates and less protein, a pattern that is linked to Types 2 DM progression[5]; and

Whereas, The American Academy of Pediatrics and the American Academy of Family Physicians recognizes food insecurity as a major social determinant of health and advocates for federal and local policies that support access to adequate healthy food[6-7]; and

Whereas, a food desert is defined as an area that lacks access to affordable and healthy food and is typically used to describe low-income rural and urban neighborhoods that either do not

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have a nearby grocery store or where a large portion of residents are unable to travel to or afford the existing healthy food[8]; and

Whereas, a food swamp is defined as an area with abundant access to unhealthy foods and fast food restaurants and limited access to healthy foods and grocery stores[9]; and

Whereas, a food mirage is defined as an area where grocery stores exist but their prices make them inaccessible to low-income families[10]; and

Whereas, the lack of access to healthy foods and increased prevalence of low price stores that promote junk foods are important factors in obesity and chronic disease among individuals in a food desert[11]; and

Whereas, according to The Food Trust "A study of nearly 4,000 adults living in New Orleans found that each additional supermarket in a participant's neighborhood is associated with reduced risk for obesity, while fast-food and convenience store access are predictive of greater odds of obesity"[12]; and

Whereas, an estimated 13.5 million people in the United States have low access to a supermarket or large grocery stores, with 82% of these individuals living in urban areas[8]; and

Whereas, 23.5 million people live in low-income areas that are more than 1 mile from a supermarket, which represents 8.4% of the US population[8]; and

Whereas, in any given year, 13% of households are car-less and 45% of families in poverty do not own a car[13-14]; and

Whereas, many low-income households cannot afford the cost of traveling to a supermarket outside their neighborhood[15-16]; and

Whereas, minority communities are frequently found to have decreased availability of supermarkets, grocery stores, and affordable healthy foods and increased prevalence of convenience stores and fast food restaurants[17-19]; and

Whereas, the defining characteristic of communities with limited food access are higher levels of racial segregation and income inequality in urban areas and lack of transportation infrastructure in rural areas[20]; and

Whereas, according to the Robert Wood Johnson Food Foundation, the federally funded community-based Healthy Food Financing Initiative (HFFI) supported Mandela Partners' distribution of "650,000 pounds of fresh produce, 46% of which comes from small family farms within 200 miles of Oakland, helping keep farmers on the land and increasing their income by over $300,000", and "increasing access to nutritious food in low-income communities and communities of color" [21-23]; and

Whereas, implementation of the community-based Healthy Navajo Stores Initiative to increase produce availability in a food desert and the Navajo Fruit and Vegetable Prescription Program (a food voucher program) resulted in a significant increase in the likelihood of individuals purchasing produce, especially at independently owned stores, and in one study cohort,

participating families increased their produce consumption by 48% and child BMI decreased by 41%[24-25]; and

Whereas, non-profit and community-driven supermarket interventions in food deserts have been shown to be more likely to remain open long-term compared to government-driven or commercial-driven models, suggesting that community engagement is a necessary component of sustainable food access interventions[26]; and

Whereas, current AMA policy (D-150.978) expresses the need for healthcare to support and model ecologically sustainable food systems and "encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation"; and

Whereas, current AMA policy (H-150.925) only encourages the study of problems concerning "food mirages, food swamps, and food oases as food environments distinct from food deserts", there is no policy highlighting the importance of food access on health and health inequality; therefore be it

RESOLVED, That our AMA amend policy H-150.925, Food Environments and Challenges Accessing Healthy Food by insertion and deletion as follows,

> **Food Environments and Challenges Accessing Healthy Food H-150.925**
> Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.

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

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel

application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

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

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

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 083
(November 2020)

Introduced by: Justin T. White and Luke Byerly, University of Louisville School of Medicine
Sponsored by: Region 5, Region 6

Subject: Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Food and Drug Administration (FDA) sets forth labeling requirements for over-the-counter (OTC) drugs and does not require the inclusion of carbohydrate content on orally ingested over-the-counter medication labels[1];

Whereas, The FDA requires that dose information about sodium, calcium, magnesium, and potassium content be listed on OTC medication labels for individuals with specific medical conditions (kidney stones, kidney disease) and/or restrictive diets (sodium-restricted diet, calcium-restricted diet, magnesium-restricted diet, potassium-restricted diet)[1]; and

Whereas, The FDA requires OTC medication labels to indicate if they contain phenylalanine and aspartame to inform consumers with phenylketonuria[2]; and

Whereas, Several orally ingested OTC medications contain a significant amount of carbohydrate, including some as high as 42 grams of carbohydrate per recommended dose (Acetaminophen liquid suspension – 42.2 g)[3-5]; and

Whereas, Carbohydrates are the major macronutrient of concern in glycemic management and carbohydrate consumption directly affects postprandial glucose in individuals with diabetes[6]. Accordingly, individuals with diabetes may observe carbohydrate-restricted diets to improve glycemic control[7]; and

Whereas, Individuals with insulin-dependent diabetes must make insulin adjustments appropriately in proportion to carbohydrate consumption to maintain adequate glycemic control[8-12]; and

Whereas, Ketogenic diets consist of high-fat and low-carbohydrate consumption, mimicking the fasting state resulting in the use of fats as a primary fuel source and causing the production of ketone bodies[13,17,18]; and

Whereas, More than 70% of patients with refractory epilepsy have shown benefit from carbohydrate-restricted ketogenic diets[13-16,21]; and

Whereas, The dietary needs of patients managing epileptic seizures through ketogenic diets require strict individual monitoring of carbohydrate consumption and clinicians may adjust carbohydrate restriction on a patient-by-patient basis with an average carbohydrate restriction of 5% of daily energy intake[13,15,16,19,20,21]; and

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Whereas, Consumption of carbohydrates in OTC medications may inadvertently exceed patients' carbohydrate restrictions, posing a serious medical risk for some patients on a ketogenic diet[22]; and

Whereas, Consumers with diabetes and individuals utilizing a ketogenic diet lack sufficient information from orally ingested OTC medication labels to make informed decisions about their consumption[3,23]; and

Whereas, The AMA's policy supporting nutrition label revision and FDA review of added sugars (D-150.974) recommends that labelling include percent recommended daily value (DV%) and encourages the FDA to develop front-of-package labels that identify foods high in added sugars; and

Whereas, The AMA encourages the FDA to "limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims: (D-150.974); therefore be it

RESOLVED, Our AMA encourages the Food and Drug Administration to require the inclusion of carbohydrate content, in grams or micrograms, on labels for orally ingested over-the-counter drugs.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.

2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.
Res. 422, A-14Appended: Res. 903, I-18

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948

Our AMA supports federal legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.
Res. 411, A-04 Reaffirmation A-07

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936

1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.

2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.
Res. 424, A-10

Recommendations on Folic Acid Supplementation, H-440.898

Our AMA will:
(1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD);

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(2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD;
(3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states;
(4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products;
(5) urge the Food and Drug Administration to increase folic acid fortification to 350 ?g per 100 g of enriched cereal grain; and
(6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and
(7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label.
CSA Rep. 8, A-99Modified: CSAPH Rep. 6, A-06, Reaffirmed: CSAPH Rep. 1, I-13

AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages, H-30.940
(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college

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and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.
CSA Rep. 1, A-04 Reaffirmation A-08, Reaffirmed: CSAPH Rep. 01, A-18

Prescription Product Labeling, H-115.994
1. The official labeling should not be regarded as the sole standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA establish the parameters governing advertising or promotion of the drug product.

2. Our AMA will advocate that the FDA work to establish a process whereby the official drug labeling can be updated in a more expeditious fashion when new evidence becomes available affecting the clinical use of prescription medications and that evidence-based standards or peer-reviewed medical literature can add to legacy information contained in official drug labeling statements to guide drug administration and usage.
Sub. Res. 30, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Modified: CSAPH Rep. 1, A-10 Modified: Res. 505, A-15

Prescription Labeling, H-115.974
Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".

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(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.
BOT Rep. 1, A-95 Amended: CSA Rep. 2, I-99 Modified Res. 512, I-00 Reaffirmed: CSA Rep. 6, A-02 Reaffirmed: CSAPH Rep. 2, A-07 Reaffirmed: Sub. Res. 509, A-07 Reaffirmed: CSAPH Rep. 01, A-17 Reaffirmation: A-19

Expiration Dates and Beyond-Use Dates of Prescription and Over-the-Counter Drug Products, H-115.983
Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription and over-the-counter drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA); (2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products; (3) urges the FDA to work with the pharmaceutical industry and the USP to develop a schedule for the review and re-evaluation of expiration dates of prescription and over-the-counter drug products; (4) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary; and (5) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products.
BOT Rep. O, I-90 BOT Rep. 1, A-95 Appended: Res. 527 and Reaffirmed: Res. 520, A-00 Modified: CSA Rep. 1, A-01 Reaffirmed: Res. 515, A-02 Reaffirmation A-07 Reaffirmed in lieu of Res. 920, I-10 Reaffirmation A-11 Modified: Res. 522, A-15

Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants and Schools 150.015MSS
AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu items, available to their customers on request.

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(MSS Res 22, I-03) (AMA Sub Res 411, A-04 Adopted in Lieu of Res 411 and 430 [H-150.948]) (Reaffirmed: MSS Rep E, I-08) (Amended: MSS Res 31, A-11) (AMA Res 914, I-11 Referred) (Reaffirmed: MSS GC Report A, I-16)

Accurate Reporting of Fats in Nutritional Labels 150.021MSS
AMA-MSS will ask the AMA to urge the FDA to use the most accurate and scientific processes to measure the fat content in foods, particularly trans fats and saturated fats, and that the most accurate fat content information based on these processes be included on food labeling. *(MSS Sub Res 29, I-09) (AMA Res 412, A-10 Adopted [H-150.939]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)*

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 084
(November 2020)

Introduced by: Bradley Fleming, Roy J. and Lucille A. Carver College of Medicine; Christopher Wong, Baylor College of Medicine; Isabella Mak, University of Alabama at Birmingham School of Medicine; Humsini Viswanath, Texas A&M College of Medicine; Rachana Raghupathy, Northeast Ohio Medical University

Sponsored by: N/A

Subject: Ensuring the Best In-School Care for Children with Epilepsy

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Epilepsy is the most common childhood neurological disorder; affecting nearly 1 in every 150 children[1-3]; and

Whereas, Childhood epilepsy presents unique challenges compared to adult epilepsy, including social difficulties, academic obstacles and learning disabilities[4-6]; and

Whereas, Most individuals with epilepsy attend some form of school outside of their home, thus it is important to assure their safety by addressing the need in school settings, which includes not only the classroom, but also school bus transportation and off-campus activities[3]; and

Whereas, Seizures are the third leading cause of school emergency[7]; and

Whereas, School nurses play an essential role in emergency preparedness, health education, and individualized disease management, including epilepsy management[8]; and

Whereas, A survey found only 67% of school nurses felt confident handling seizure clusters, only 63% felt confident administering the emergency seizure rescue drug midazolam, and only 47% felt confident swiping a child's vagus nerve stimulator[7]; and

Whereas, School nurses in suburban and urban settings are not likely to be available to assist at the time of the seizure[7]; and

Whereas, School nurses identified the lack of staff training and knowledge about seizures as the greatest obstacle for children with epilepsy[9]; and

Whereas, School nurses were not confident that other school staff could identify a seizure[7]; and

Whereas, The American Academy of Pediatrics recommends that school personnel be aware of emergency intervention measures including administering seizure medication in many circumstances where other options are not feasible, such as when school nurses are not available[3]; and

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Whereas, School nurses felt that current documentation often did not have enough detailed information and left school staff uninformed about children's specific epilepsy diagnosis, seizure presentation, and emergency care needs[7,9]; and

Whereas, A major contributor to emergency department utilization for children with epilepsy is inadequate or lack of rescue seizure therapies[7]; and

Whereas, Use of rescue seizure therapies do not require a medical license to administer and are often designed so that they can be handled by non-medical staff[7]; and

Whereas, Liability concerns, privacy issues, and prohibitive school policies currently limit the ability of school staff to administer rescue medicine[7]; and

Whereas, School nurses have asked for more uniform education content and resources, such as a standardized training program for school staff, and have expressed a need for improved communication between nurses, teachers, parents, and children's health care providers[9]; and

Whereas, A trial implementation of a standardized seizure preparedness and quality improvement project led to 88% of newly diagnosed children completing epilepsy care documentation in school records, and improved school nurses' confidence in understanding components of seizure action plans, in knowing how to create safe learning environments, in knowing how to train other staff members, and in knowing what medical and social supports are available[9]; and

Whereas, Epilepsy training programs for teachers and social workers have been shown to significantly improve school staff's understanding of acute epilepsy management and readiness to administer rescue medication[10]; and

Whereas, The Epilepsy Foundation of America has prioritized the Seizure Safe School initiative; calling for legislation promoting seizure identification and response training, increased use and availability of seizure action plans, increased access and storage of FDA-approved anti-epileptic medication, and additional educational training for students regarding epilepsy[11]; and

Whereas, 5 states have passed Seizure Safe School legislation, an additional 14 states have introduced legislation, and 14 states are targeted to introduce legislation in 2020[11]; and

Whereas, AMA policies H-60.974, H-60.981, and H-60.991 describe current healthcare partnerships to optimize pediatric health in schools, but the challenges of pediatric epilepsy go beyond what is addressed in these policies; and

Whereas, AMA policies H-350.973 and H-60.932 provide frameworks that lend additional support to students with serious pediatric health conditions, such as sickle cell disease and diabetes; therefore be it

RESOLVED, That our AMA supports evidence-based initiatives to optimize in-school care for children with epilepsy, including but not limited to (1) seizure recognition and first-aid response training for teachers and school personnel; (2) the inclusion of seizure action plans within school records to be accessed easily by all school personnel; and (3) accessibility to, and storage of, emergency seizure rescue medications in schools.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Children and Youth With Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;

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(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

Policy Timeline: CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11

Adolescent Health H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.

Policy Timeline: Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17
Providing Medical Services through School-Based Health Programs H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

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Policy Timeline: CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

Sickle Cell Disease H-350.973

Our AMA:
(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease.

Policy Timeline: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Modified: BOT Rep. 12, A-11; Appended: Res. 906, I-19

Ensuring the Best In-School Care for Children with Diabetes H-60.932

Our AMA policy is that physicians, physicians-in-training, and medical students should serve as advocates for pediatric patients with diabetes to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections.

Policy Timeline: CSAPH Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 085
(November 2020)

Introduced by: Danielle Rivera, Remy Link, University of New Mexico School of Medicine; Kseniya Anishchenko, University of Colorado School of Medicine

Sponsored by: Region 1, Asian Pacific American Medical Student Association

Subject: Call for Improved Personal Protective Equipment (PPE) Design and Fitting

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The National Institute for Occupational Safety & Health (NIOSH) defines personal protective equipment (PPE) as "equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses[1];" and

Whereas, The NIOSH definition includes items such as gloves, masks, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests and bodysuits[1]; and

Whereas, Currently, "unisex" PPE is designed for European males and does not adequately reflect the diversity in body types[2-6]; and

Whereas, Minorities, especially east Asian racial groups, and women, are more likely to struggle to find PPE that fits appropriately[2-10]; and

Whereas, A 2016 Trade Union Congress survey found that only 29% of women used PPE that was specifically designed for women and that 57% of women reported that improperly fitted PPE sometimes or significantly hampered their work[3,4]; and

Whereas, Improperly-fitted PPE puts users at risk for injuries, including tripping from too large shoes, losing grip on items because of gloves that don't fit, or in some settings, can lead to back pain or foot injuries;[3-6] and

Whereas, During the COVID-19 pandemic, studies have reported healthcare providers developing pressure ulcers from attempting to form a seal with their masks[11,12]; and

Whereas, Improperly-fitted PPE can cause their users added psychological stress due to safety concerns while working[13,14]; and

Whereas, At least some health-care professionals have contracted who were diagnosed with COVID-19 and were found to have improperly fitted masks[15-,18]; and

Whereas, Properly fitting masks reduce healthcare professionals' risk of contracting COVID-19[15]; and

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Whereas, A study of healthcare workers involved in aerosol-generating procedures found that women had an increased hazard ratio of contracting COVID-19 of 1.36 after controlling for confounding factors[17,18]; therefore so be it

RESOLVED, That our AMA will encourage the diversification of personal protective equipment design to better fit the diversity of body types among healthcare workers, including PPE specifically designed for women's and minorities' bodies.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Protecting Medical Trainees from Hazardous Exposure H-295.939

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.

2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to mnimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff. Sub. Res. 229, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME/CSAPH Joint Rep. 01, A-19

8.4 Ethical Use of Quarantine and Isolation

Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the

health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.

With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:

(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.

(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.

(c) Encourage patients to adhere voluntarily to quarantine and isolation.

(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.

(e) Inform patients about and comply with mandatory public health reporting requirements.

(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.

(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.

The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:

(h) Ensure that quarantine measures are ethically and scientifically sound:

(i) use the least restrictive means available to control disease in the community while protecting individual rights;

(ii) without bias against any class or category of patients.

(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.

(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.

(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.

(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

Issued: 2016

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 086
(November 2020)

Introduced by: Rita Kumar, Varsha Venkatakrishna, Divya Seth, Danielle Thor, Touro College of Osteopathic Medicine - Harlem

Sponsored by: N/A

Subject: Medically Unnecessary Procedures on Intersex Patients

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Intersex is a general term used to describe a person whose reproductive or sexual anatomy does not fit the prevalent binary standard of “male” or “female,” such as those with Androgen Insensitivity Syndrome (AIS), X0 Turner syndrome, XXY Klinefelter syndrome, Congenital Adrenal Hyperplasia (CAH) and others[1,2];and

Whereas, Persons born intersex have historically been viewed as having a medical disorder, categorized within 3 subgroups (sex chromosome DSD, 46XX DSD, and 46XY DSD) where their bodies are often pathologized and seen as “emergencies that necessitate medical attention” [3,4]; and

Whereas, Current genital intersex surgery comprises 4 main components: (1) surgery of general tubercle, (2) management of Mullerian structures, (3) surgery of gonads, and (4) refashioning of the perineum -- summarized in layman terms as: genitoplasties and gonadectomies[4,5]; and

Whereas, There is a lack of clinical evidence supporting the need for genitoplasties and gonadectomies on intersex infants[5]; and

Whereas, According to a 2016 clinical review, there is no consensus on surgery indications, timing, procedures, or outcome evaluations, and no evidence on the “impact of intervention or non-intervention during [infancy] of affected persons”, indicating the lack of an established standard of care[4,5]; and

Whereas, Physicians opt to do medically unnecessary genital surgery on intersex infants in efforts to “normalize” the patients’ sexual anatomy to fit the prevalent societal binary of male and female[3]; and

Whereas, Three former US Surgeon Generals have argued that “children born with atypical genitalia should not have genitoplasty performed on them absent a need to ensure physical functioning, and that cosmetic genitoplasty should be deferred until children are old enough to voice their own view about whether to undergo the surgery”[6].

Whereas, the Yale Law Review and several prominent international physicians and legal scholars have contested the current capacity of physicians to obtain valid informed consent from

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the parents or legal guardians of intersex children prior to providing medically unnecessary gender-altering surgeries[7-14]; and

Whereas, Modern bioethicists argue that imposing medically unnecessary gender-altering surgeries on intersex children violates their human rights by “dehumanizing” them until they are surgically forced into the gender binary, instead of allowing them to naturally grow into their gender and then employ the gender binary later in life as they see fit[15-18]; and

Whereas, Reported long-term outcomes of genitoplasty on intersex infants have included: severe surgical complications, sterilization, decreased sexual function and arousal, and gender dysphoria[19-22]; and

Whereas, A clinical review investigating the long-term effects of pediatric genitoplasties on CAH patients reported that 48% of individuals experienced uncomfortable intercourse as adults and 33% developed vaginal stenosis, a severe complication[19]; and

Whereas, A study concluded that 46XY DSD adults who had undergone genitoplasties during infancy experienced significantly decreased sexual satisfaction and clitoral arousal due to the procedure[20]; and

Whereas, An additional study showed that 36% of intersex patients who underwent genitoplasties as infants reported severe complications, including urethrocutaneous fistulas, penoscrotal fistulas, glans dehiscence, and urethral dehiscence[21]; and

Whereas, Further studies stipulated that 26% of intersex participants reported life-long gender dysphoria due to incorrect gender assignments by their surgeons at birth[22]; and

Whereas, Studies have called to fill the research gap in long-term mental and physical outcomes of intersex surgical procedures, including: quality of life, fertility, sexual function and satisfaction, and gender dysphoria[4,5,23,24]; and

Whereas, In recognition of the lack of data surrounding this patient population, academic institutions have collaborated in an international effort to encourage longitudinal research assessing the post-genitoplastic outcomes of intersex patients[26]; and

Whereas, Genitoplasties on intersex infants have been condemed by several medical organizations, including: United Nations (UN), World Health Organization (WHO), American Academy of Family Physicians (AAFP), and Physicians for Human Rights (PHR)[26-30]; and

Whereas, AAFP stipulates genital surgeries for intersex infants should only be reserved for resolving a critical functional impairment or reducing the risk of developing a life-threatening condition[27]; therefore be it

RESOLVED, That our AMA recognize intersex infants should not undergo genitoplasty unless the procedure resolves a functional impairment that if left untreated would likely endanger the life of the patient; and be it further

RESOLVED, That our AMA work with relevant stakeholders to research factors impacting genitoplasty outcomes in intersex individuals, such as: the safety and complications of genitoplasty on intersex individuals (especially those under 5 years of age); whether genitoplasty has a meaningful impact on intersex patients’ long-term mental and physical health

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outcomes (e.g. quality of life, sexual function and satisfaction, and gender identity); key factors required to establish standardized indications for genitoplasty on intersex infants; trends in satisfaction with patient counseling and patient involvement in surgical decision-making.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Ban Conversion Therapy D-515.978
Our AMA will develop model state legislation and advocate for federal legislation to ban "reparative" or “conversion” therapy for sexual orientation or gender identity. Res. 10, I-19

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967
Our AMA supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner

Affirming the Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth. Res. 003, A-17Modified: Res. 005, I-18

Pediatric Decision Making E-2.2.1
As the persons best positioned to understand their child’s unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children’s capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children’s physical health and well-being and to nurture their children’s developing personhood and autonomy.

But parents’ authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek

minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:
(a) Provide compassionate, humane care to all pediatric patients.
(b) Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
(c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
(d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
(e) Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.
(f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
(g) When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
(h) When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource.
Issued: 2016 Amended: 2019

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 087
(November 2020)

Introduced by: Rajadhar Reddy, Baylor College of Medicine; Swetha Maddipudi, University of Texas Health Science Center at San Antonio Long School of Medicine; Rishi Goel, University of Texas Health Science Center at Houston McGovern Medical School

Sponsored by: Region 3, Region 4, Region 6

Subject: Expungement and Sealing of Drug Records

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The National Academies of Sciences, Engineering, & Medicine, in their 2017 consensus report *Communities in Action: Pathways to Health Equity*, wrote that "the criminal justice system is a key actor, setting, and driver of public safety as it relates to health equity" and that "specifically, the criminal justice system's role in the mass incarceration of racial and ethnic minorities is an important factor when examining the social determinants of health"[1]; and

Whereas, Research using has demonstrated associations between previous involvement in the criminal justice system, re-entry into communities, and health outcomes relating to obesity, HIV/AIDS, substance use, sexual abuse, and general use of health services[2,3,4,5,6]; and

Whereas, Of 2.3 million individuals incarcerated in US federal prisons in 2006, an analysis demonstrated that 85% used addictive substances, 65% met psychiatric criteria for a substance use disorder, and 20% committed crimes related to substance use or possession[7]; and

Whereas, In 2006, addictive substances were involved in 78% of violent crimes, 83% of property crimes, and 77% of public order, immigration, weapon, probation, and parole offenses or violations[7]; and

Whereas, Individuals with public records of past illicit substance use and possession can face discrimination in many aspects of life, such as employment, housing, eligibility for public benefits, eligibility for educational financial aid, professional licensure, and enrollment in the military, which are aspects related to social determinants of health[1,8,9,10]; and

Whereas, "Expungement" refers to destroying public records and "sealing" refers to removing public access and only allowing law enforcement to view these records[8]; and

Whereas, Several states, such as California, Colorado, Maryland, New Hampshire, and Oregon have taken recent strides to increase individuals' ability to expunge and seal public records, particularly those with nonviolent "low-level" offenses related to substance use[11];

Whereas, In particular support of individuals with records of juvenile offenses, at least 15 states have legislation automatically expunging or sealing juvenile records under certain conditions, and many more states are considering these measures[12]; therefore be it

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RESOLVED, That our AMA support efforts that allow individuals to expunge or seal public records of past illicit substance use or possession.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

H-95.954: The Reduction of Medical and Public Health Consequences of Drug Abuse
Our AMA: (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 088
(November 2020)

Introduced by: Michael Franklin, Connor R. Buechler, Katanya C. Alaga, Michael Moentmann, Lakshmi Guduguntla, Leya Maliekal, Hannah Gloede, Anneliese Petersen, Mara Darian, Danielle Rangel, Josee Smith, Ana Lanier, Anthony Seely, Wayne State University School of Medicine

Sponsored by: Region 5

Subject: Increased attention to hygiene facilities

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Homeless individuals are at a high risk for contracting a wide variety of communicable diseases, many of which are related to poor hygiene including lice, foot infections, scabies, tuberculosis, viral hepatitis, respiratory infections, community acquired pneumonia, RSV, flu-like illnesses, *Bartonella quintana*, and *Rickettsia prowazekii*[1-5]; and

Whereas, In the ongoing 2016 outbreak of Hepatitis A Virus, 34% of reported cases were among homeless individuals and attributed to poor hygiene[6]; and

Whereas, Homeless individuals are more frequently hospitalized for infectious diseases, and their hospitalizations cost on average $2,000-$4,000 more than those of their non-homeless counterparts[1,7,8]; and

Whereas, Emergency department frequent users are disproportionately homeless, and homeless frequent ED users accrue on average $64,000 in charges per year[9]; and

Whereas, Difficulty meeting subsistence needs, such as bathing and using the restroom, makes homeless adults less likely to seek preventive care or care early in the course of illness[10,11,12]; and

Whereas, The homeless population has daily showering rates of approximately 34%[13]; and

Whereas, Homeless individuals report barriers to accessing public shower and restroom facilities such as lack of public facilities, poor facility sanitation, length of wait times, and concerns of theft[13, 14]; and

Whereas, The implementation of a standalone, public, 24-hour public restroom facility in San Antonio has been linked to indicators of increased public cleanliness, including a 70% decrease in public urination citations[15]; and

Whereas, The United Nations High Commission for Refugees has established standards for hygienic living conditions for temporary shelter, recommending a ratio of 1 toilet per 20 people, a ratio which U.S. municipalities do not meet[16, 17]; and

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Whereas, Although current public hygiene infrastructure exists in major cities such as Los Angeles, Portland, St. Louis, Boston, and Seattle to provide non-shelter public restroom facilities to persons experiencing homelessness, the onus is primarily placed upon cash-strapped not-for-profit organizations to source funding and maintain cleanliness and functionality[18]; and

Whereas, Our AMA supports improving health outcomes and reducing healthcare costs for homeless individuals by addressing environmental factors and encouraging comprehensive policies to support the social needs of homeless patients (H-160.903), but does not draw attention to the need for hygiene facilities for homeless individuals; therefore be it

RESOLVED, That our AMA amend policy H-160.903 Eradicating Homelessness, by addition and subtraction as follows:

Eradicating Homelessness, H-160.903

Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(5) calls upon relevant social service organizations and governments to increase access to safe and sanitary hygiene facilities, including public showers and restrooms;

(~~5~~ 6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(~~6~~ 7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;

(~~7~~ 8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

(~~8~~ 9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

(~~9~~ 10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and

policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and

(~~10~~ 11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Eradicating Homelessness H-160.903

Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

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(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
(Res. 401, A-15) (Appended: Res. 416, A-18) (Modified: BOT Rep. 11, A-18) (Appended: BOT Rep. 16, A-19) (Appended: BOT Rep. 28, A-19)

The Mentally Ill Homeless H-160.978

(1) The AMA believes that public policy initiatives directed to the **homeless**, including the **homeless** mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for **homeless** persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the **homeless** population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the **homeless**; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the **homeless** population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the **homeless** population.
(BOT Rep. LL, A-86) (Reaffirmed: Sunset Report, I-96) (Reaffirmed: CMS Rep. 8, A-06) (Reaffirmed: CMS Rep. 01, A-16) (Reaffirmed: BOT Rep. 16, A-19)

Eradicating Homelessness 440.048MSS
AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness.
(MSS Res 33, A-14) (Reaffirmed: MSS GC Rep A, I-19)

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in theUnited States 440.060MSS
AMA-MSS will ask that our AMA amend policy H-160.903 by addition and
deletion to read as follows:
Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without

mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.
(MSS Res 38, I-16) (AMA Res 208, A-17 Referred)

Opposition to Measures That Criminalize Homelessness 440.066MSS
AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that requires nondiscrimination against homeless persons, such as homeless bills of rights.
(MSS Res 20-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 089
(November 2020)

Introduced by: Ikram Rostane, Aishu Rao, Natasha Topolski, McGovern Medical School at the University of Texas Health Science Center at Houston; Rajadhar Reddy, Baylor College of Medicine
Sponsored by: Region 1, Region 2, Region 3, Region 4

Subject: Providing Reduced Parking for Patients
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In the United States, an estimated four million individuals fail to receive annual medical care due to transportation barriers[1]; and

Whereas, Many patients with common illnesses attend multiple outpatient appointments a year, such as one study which showed 47% of patients with hypertension had four or more visits in 2014[2]; and

Whereas, Parking prices at some of the country's largest medical centers can be as high as $20 to $43 per day[3-4]; and

Whereas, The public transportation system in the United States varies greatly within the country in terms of usage, location, and infrastructure, with most of the public transport concentrated in the Northeast[5]; and

Whereas, Approximately only a third of patients are within walking distance to their nearest public transportation in certain metropolitan medical centers[6]; and

Whereas, Public transport is not readily available in all locations, such as rural areas where the scarcity of local physicians can still require patients to drive to urban areas for care[7]; and

Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often limited to approved patients within Medicaid and can have many disadvantages, including restrictions on the type and number of rides, the necessity of a social worker to coordinate transportation, having to schedule days in advance, and carpooling with other patients leading to longer travel and wait times[8]; and

Whereas, The average cost of an NEMT in 2014 was $28, and this price rises in rural and suburban areas that are farther from medical centers[8,9]; and

Whereas, When surveying older Americans, the group that utilizes the most inpatient and outpatient healthcare, rideshare services were not seen as a practical option, with 74% of patients reporting no knowledge of these services and only 1.7% making use of them[10]; and

Whereas, In a study of patients with heart disease, individuals reported the high cost of parking at healthcare facilities as a financial barrier to attending multiple specialist appointments[11]; and

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Whereas, In a study of factors influencing family burden in pediatric hematology/oncology, parking was cited as one of the most disproportionately distressing factors[12]; and

Whereas, Nonmedical costs, such as transportation, meals, and child care, have been reported to range from $50 to $165 a day, further contributing to a family's financial stress[13]; and

Whereas, The lower the financial burden a patient has, the less likely they are to miss appointments and adhere to treatment, preventing high cost emergent situations that would lead to hospitals losing money on patients who cannot pay[14]; and

Whereas, Reduced parking fees have been cited as an incentive for patients to travel to hospitals that can offer better treatment than local counterparts[15]; and

Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses, such that providing parking vouchers would only represent a minor loss in revenue while providing a major benefit to patients[16]; and

Whereas, Many hospitals have already implemented programs for patient parking such as reduced monthly rates and free validated parking[17-19]; and

Whereas, Several associations of healthcare facilities focus on developing solutions for and advocating improvements in social and economic aspects of healthcare, including the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association[20-27]; and

Whereas, The American Hospital Association is a national organization of "5,000 hospitals, health care systems, networks, [and] other providers of care" and publishes standards and guidelines on various social and economic aspects of care[20,21]; and

Whereas, The Federation of American Hospitals is a national organization of over 1,000 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their priorities[22-24]; and

Whereas, The Children's Hospital Association is a national organization of over 220 pediatric hospitals and develops and shares solutions with its members on various social and economic aspects of care[26,27]; therefore be it

RESOLVED, That our AMA works with relevant stakeholders, such as the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association, to encourage healthcare facilities to recognize parking fees as a burden of care for patients and to implement mechanisms for reducing parking costs.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Non-Emergency Patient Transportation Systems H-130.954
Our AMA:
1. supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and

2. encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. Sub. Res. 812, I-93

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. Sub. Res. 75, I-81

Voluntary Health Care Cost Containment H-155.998
1. All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature.

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2. Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. Res. 34, A-78

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; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 090
(November 2020)

Introduced by: Alyssa Tuan, Pennsylvania State University College of Medicine; Lauren Lin, University of Pittsburgh School of Medicine

Sponsored by: Region 6, Asian Pacific American Medical Student Association

Subject: Naming of New Infectious Pathogens and Diseases

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, During official press conferences and public events, U.S. leadership has repeatedly called Coronavirus disease (COVID-19) and SARS-CoV-2 other names, including the “China virus,” “China plague,” “Wuhan virus,” and “Kung Flu”[1,2,3,4,5]; and

Whereas, U.S. leadership justified the use of the terms to highlight the origin of where the disease and virus came from[6,7,8,9]; and

Whereas, While historically, infectious diseases have been named for the geographic location they were thought to originate from, this trend has not happened for some time due to being offensive and having unintended negative consequences[10]; and

Whereas, In order to decrease the use of disease names that might result in discriminatory behavior against places or ethnic groups, the World Health Organization (WHO) released more stringent guidelines for naming infectious diseases in May 2015[11]; and

Whereas, WHO best practices for naming new human infectious diseases include using generic or specific descriptive terms that highlight characteristics of the disease (such as "respiratory disease" or "progressive," respectively), or using the causative pathogen, if known, as part of the disease name (such as "novel coronavirus respiratory syndrome")[11]; and

Whereas, WHO best practices also include avoiding the use of geographic location; people’s names; cultural, population, industry or occupational references; species/class of animal or food; and terms that incite undue fear[11]; and

Whereas, Stigmatization and discrimination during an infectious disease outbreak can undermine timely treatment and recovery, as well as contribute to adverse health outcomes[12,13,14,15]; and

Whereas, Asian Americans have experienced increased discrimination during the coronavirus pandemic ranging from verbal harassment to physical assault[16,17,18,19]; and

Whereas, A man stabbed two Asian American children and their father at a Sam's Club in Texas, an incident the Federal Bureau of Investigation (FBI) called a hate crime[20]; and

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Whereas, A reporting system called "Stop AAPI Hate" created by a professor at San Francisco State University collected more than 650 such reports in the site's first eight days[21]; and

Whereas, Experts have suggested that U.S. leadership has stoked such bias by referring to the coronavirus as "the Chinese virus"[20,22,23,24]; and

Whereas, Men who had sex with men were discriminated against in the early 1980s during the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic in the U.S., a new infectious disease that was colloquially referred to as “gay-related immune deficiency”[25,26,27]; and

Whereas, Discrimination against West Africans in the U.S. also occurred in 2014-2015 during the outbreak of Ebola virus disease, which was named according to where it was first discovered[28,29]; and

Whereas, A United Nations representative stated that, “Governments must ensure that their response to the COVID-19 pandemic does not contribute to xenophobia and racial discrimination, and must eradicate xenophobia throughout all...policy and messaging”[30]; and

Whereas, The Congressional Asian Pacific American Caucus of the U.S. House of Representatives wrote a letter urging fellow Members of Congress to help stop the spread of xenophobia and misinformation by only sharing confirmed and verifiable information pertaining to COVID-19, how it spreads, and how Americans should protect themselves[31]; and

Whereas, In May 2020, the AMA denounced the use of racially charged terms such as “the Wuhan virus” that perpetuate cultural biases and otherize minority groups[32]; and

Whereas, Then-AMA President Dr. Patrice Harris stated that, “The AMA strongly condemns xenophobic and race-based scapegoating against Asians and Pacific Islanders in America and against Asian-presenting people. Racism and xenophobia lead to negative health consequences for segments of our population and this shouldn’t be tolerated”[32]; and

Whereas, The AMA opposes discrimination and recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States (H-65.965); and

Whereas, The AMA also urges expedient passage of appropriate hate crimes prevention legislation (H-65.965); therefore be it

RESOLVED, That our AMA support the naming of new human infectious diseases and pathogens—including colloquial names—that avoid references to geographic location, peoples, and cultures; and be it further

RESOLVED, That our AMA denounce actions that discriminate against any group of individuals who have been related to a new infectious pathogen based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

World Health Organization H-250.992

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16; Reaffirmed: BOT Rep. 23, A-18

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

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B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics. Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

Disseminating Information to Combat Ethnic Retaliation and Racism 65.005MSS
AMA-MSS will work to raise awareness about incidents of ethnic retaliation and racism with the goal of reducing the occurrence of such incidents in the future. (MSS Sub Res 7, I-01)

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(Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Human Rights as the Foundation of Public Health: The MSS formally establishes support for the following HOD policy: World Health Organization H-250.992
The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. (BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16) (MSS Res 19, A-17)

Hate Crimes 270.016MSS
AMA-MSS will ask the AMA to recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States. (MSS Amended Late Res 8, I-98) (AMA Amended Sub Res 228, I-98 Adopted [H-65.980]) (Reaffirmed: MSS Rep E, I03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 091
(November 2020)

Introduced by: Whitney Stuard and Shyon Parsa, UT Southwestern Medical School

Sponsored by: Region 3, Association of Native American Medical Students

Subject: Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Processes

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Association of American Medical Colleges (AAMC) has halted the applications for all in person audition electives and encouraged universities to create local substitutes due to the COVID-19 pandemic[1-3]; and

Whereas, Audition electives are commonly referred to as away-rotations and will be referred to in this way for the remainder of this resolution[4]; and

Whereas, Medical students in the past have used away-rotations as a way to alleviate geographical disadvantages, which include the lack of their specialty of choice at their home institution[1,3,5]; and

Whereas, Away rotations are critical for obtaining novel education, assessing applicants “fit” to a program, and career exploration[5-7]; and

Whereas, the Electronic Residency Application Service stated 67% of medical students applying to residency completed an away rotation, with up to 57% in some specialties matching to either their home institution or one they rotated at[7-9]; and

Whereas, There will be inherent variation between students’ experiences working within a specialty based on their location during the COVID-19 pandemic, personal finances, and resources of their university[1,10]; and

Whereas, The Coalition of Physician Accountability recommended allowing students with specialty interest not available at their school to be allowed to perform away-rotations[4]; and

Whereas, There are no overarching guidelines that have been established[10]; and

Whereas, Many institutions will not offer rotations to outside students during the pandemic[4]; and

Whereas, Due to the decrease in away rotations, the upcoming residency cycles will greatly rely on standardized testing, causing an exacerbation in existing disparities[11-13]; and

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Whereas, For some students it will be difficult to obtain letters of recommendation (LOR) from specialty faculty when applying for residency since not all universities have all subspecialty departments [1,3,10]; and

Whereas, The value of a residency applicant's LOR from the specialty of interest, clerkship grades and subspecialty specific research are among the top factors considered by a residency program director for admission[14-17]; and

Whereas, Other medical governing bodies have recognized that medical students who cannot gain specialty involvement will be limited when applying to residency through their experience, LORs, and the information available to them about each program[18-20]; and

Whereas, One-fifth of medical students believe the COVID-19 pandemic will affect their specialty choice with 74% of students concerned about away rotations, 81% stating concerns about acquiring letters of recommendation and 73% concerned about time working in their specialty of choice[21,22]; and

Whereas, Due to the lack of away-rotations, acquiring information about residency programs will be difficult to obtain since many residency websites lack basic information concerning their program[23-25]; and

Whereas, the AMA Fellowship and Residency Electronic Interactive Database does not have functional links for all residency programs[25,26]; and

Whereas, The AMA has been a leader in discussing safe academic practices to accommodate medical students this year[2,27]; and

Whereas, Virtual away rotations are being implemented with success to allow a fair process during the pandemic[28]; and

Whereas, Virtual away rotations will decrease financial burden and disparity in the residency application processes[7,28,29]; and

Whereas, The AAMC and the AMA have not provided overarching guidance to residency programs to provide fair and equitable opportunities to all medical students applying to residency during a pandemic[1]; therefore be it

RESOLVED, That our AMA will encourage residency programs to prioritize applicants whose universities do not have home programs to have a minimum of one opportunity to participate in an in-person or virtual away rotation over students coming from an institution with a residency program in the field they are applying to; and be it further

RESOLVED, That our AMA will collaborate with the AAMC AACOMAS LCME ACGME and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents; and be it further

RESOLVED, That our AMA encourages residency programs to provide more information on their websites such as residency research achievements, fellowship match information, operative/rotation schedules, and information about where residents who have graduated now

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work to allow students who cannot participate in rotations to learn about the program; and be it further

RESOLVED, That our AMA-MSS will immediately forward this resolution to the AMA house of delegates.

Fiscal Notice: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

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5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician

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shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the

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current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Sub. Res. 314, A-07Reaffirmation I-07Reaffirmed: CME Rep. 4, I-08Reaffirmed: Sub. Res. 314, A-09Reaffirmed: CME Rep. 3, I-09Reaffirmation A-11Appended: Res. 910, I-11Reaffirmed in lieu of Res. 303, A-12Reaffirmed in lieu of Res. 324, A-12Reaffirmation: I-12Reaffirmation A-13Appended: Res. 320, A-13Appended: CME Rep. 5, A-13Appended: CME Rep. 7, A-14Appended: Res. 304, A-14Modified: CME Rep. 9, A-15Appended: CME Rep, 1, I-15Appended: Res. 902, I-15Reaffirmed: CME Rep. 3, A-16Appended: Res. 320, A-16Appended: CME Rep. 04, A-16Appended: CME Rep. 05, A-16Reaffirmation A-16Appended: Res. 323, A-17Appended: CME Rep. 03, A-18Appended: Res. 319, A-18Reaffirmed in lieu of: Res. 960, I-18Modified: Res. 233, A-19Modified: BOT Rep. 25, A-19

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance

patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

Sub. Res. 301, A-13Reaffirmation I-15Reaffirmed in lieu of: Res. 307, A-17

Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.

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3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.
CME Rep. 01, I-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 092
(November 2020)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville

Sponsored by: Region 4

Subject: Supporting the Practice of and Appropriate Reimbursement for Group Prenatal Care

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Group prenatal care is defined as a care model that brings patients with similar needs together for health care encounters in order to increase the time available for the educational component of the encounter, increase social support, improve efficiency, and reduce repetition, while maintaining some components of individual prenatal care[1,2]; and

Whereas, Group sessions include individual time with an obstetrician, socializing opportunities, and education about various topics concerning individual and child health[1,2]; and

Whereas, Group care has been used successfully in a variety of medical settings for management of chronic medical conditions such as chronic pain, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), cancer, diabetes, and congestive heart failure[3-7]; and

Whereas, One study found that patients who participate in group prenatal care obtain better prenatal knowledge, feel more prepared for labor and delivery, are more satisfied with overall care, and initiate breastfeeding more often[8]; and

Whereas, Many different models, such as the Centering Pregnancy model, Expect with Me, Pregnancy and Parenting Partners, and Expecting and Connecting, have all been used internationally with success since 1993[1]; and

Whereas, Based on the final Centering Pregnancy sample of 1262, the numbers needed to treat equate to 57 low birth weight deliveries, 51 premature deliveries, and 42 NICU babies prevented from 2009–2013[9-12]; and

Whereas, One retrospective cohort study of 207 group care patients matched with 414 traditional prenatal care patients showed similar baseline characteristics between the two groups, but group care was associated with significant reduction in low-birth-weight infants compared with individual care, a reduced number of cesarean deliveries, and a reduced need for higher level neonatal care[1,13]; and

Whereas, A retrospective five-year cohort study after implementing group prenatal care among Medicaid-insured women in South Carolina found that there was a reduced risk of low birthweight by 44%, premature birth by 36%, and neonatal ICU stays by 28%[9,14]; and

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Whereas, In order for the implementation of group prenatal care programs to be successful, it requires that adequate funds be provided, organizational structures are put in place for the programs to succeed, and commitment to improving birth outcomes and/or reducing racial disparities are necessary elements to address[1,15,16]; and

Whereas, Group prenatal care can be difficult to initiate due to start up cost, training, space limitations, and patient hesitancy to receive care within a group[15,16]; and

Whereas, Many private insurers, Medicare, and only a few states provide reimbursement or enhanced reimbursement for practices that utilize this model[1,15,16]; and

Whereas, South Carolina is one of a few states to implement Medicaid reimbursements for group prenatal care on a large scale and attempt implementation of this practice across the state[1,15,16]; and

Whereas, A study conducted in South Carolina found that investing $14,875 in Centering Pregnancy for 85 patients yielded a net savings for Medicaid of $67,293 in NICU costs[1,16]; and

Whereas, One cost analysis of group prenatal care that used actual claims paid data for women enrolled in Medicaid in South Carolina found it to be cost effective with a $2.3-million-dollar savings being reported after the initial investment[9]; and

Whereas, One cost–benefit model found that the cost of group prenatal care would be financially sustainable and possibly generate income when used in the outpatient clinic[9]; and

Whereas, The Medicaid program is the largest payer of maternity benefits in the United States, therefore improving Medicaid coverage would in turn improve access and quality of health care services provided to women and newborns[16]; therefore, be it

RESOLVED, That our AMA supports the principles and use of group prenatal care and recognizes that it is an effective method for providing prenatal care; and be it further

RESOLVED, That our AMA will advocate for equitable reimbursement rates for group prenatal care from all private and public insurances; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders and state medical associations to draft model legislation that can be used to ensure equitable Medicaid reimbursements for group prenatal care in all states.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Access to Prenatal Care H-420.978
(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.

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Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11

Prenatal Services to Prevent Low Birthweight Infants H-420.972
Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants.
Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 227, A-11

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Res. 102, A-12; Modified: Res. 503, A-17

Value of Group Medical Appointments H-160.911
Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.
Res. 713, A-13

Maternal and Child Health Care H-420.986
The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.
BOT. Rep. V, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-15

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 093
(November 2020)

Introduced by: Lavanya Easwaran, Rhiya Mittal, Daniel Beckerman, University of Miami Miller School of Medicine; Aaishwariya Gulani, University of Central Florida; Cameron Holguin, Sanjana Reddy, Joshua Carrasco, University of Texas Health Science Center San Antonio Long School of Medicine; Spencer Bayless, University of Arizona; Jerome Soldo, University of Louisville School of Medicine; Nikita Sood, Washington University in St. Louis; Samantha Rea, Wayne State University School of Medicine

Sponsored by: Region 4

Subject: Amending Policy H-50.973 to Support the Implementation of Health Care Referrals in Blood Donation Centers for Donors at Risk for HIV

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Current Food and Drug Administration (FDA) guidelines require men who have sex with men (MSM) abstain from all sexual contact for at least three months before being permitted to donate blood[1]; and

Whereas, The FDA also requires a three month deferral period for women who have sex with MSM[1]; and

Whereas, In a study, the pre-donation questionnaire (PDQ) that looks for MSM activity was found to create deferral rates that are disproportionately high in relation to the incidence of disease, indicating the questionnaire's low specificity for positive disease screenings[2]; and

Whereas, Another study showed that to prevent one case of HIV transmission through blood donation, 300,000 to 600,000 potential donors had to be deferred based on their answers to the MSM activity question in the PDQ, indicating an extremely low positive predictive value[2]; and

Whereas, 26.7% of respondents to a survey about blood donation acknowledged that they did not disclose their deferral status as MSM when donating blood[3]; and

Whereas, Spain utilizes physicians to conduct risk assessments of donors, which allows for an increase in the truthfulness to screening questions and more accurate assessment of patient risk versus non-physician screening assessments[4]; and

Whereas, LGBT populations are at higher risk for STIs, cardiovascular disease, cancers, substance abuse, obesity, bullying, and mental illness than the general public[5]; and

Whereas, Blood donation counselling is an important vector for the early diagnosis of medical conditions such as anemia or blood borne infections[6]; and

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Whereas, Many blood donations centers do not have the infrastructure to provide effective blood donation counseling while others do not consider counseling to be part of providing a quality service to donors[6]; and

Whereas, The guidelines for donor counseling developed by the World Health Organization and the International Federation of Red Cross and Red Cross Societies indicates that referrals for testing and treatment of infectious diseases are critical but does not provide standardized ways to implement this in individual donation centers[7]; and

Whereas, early detection and treatment of conditions such as HIV has shown to have better recovery for patients[8]; and

Whereas, early detection is often associated with patients' understanding of their individual risk and their ability to get tested, meaning any screening that deems a patient as high risk for HIV should follow up with a proper diagnosis via physicians[9]; and

Whereas, individuals identified early to have a high risk for HIV have a 99% chance of preventing HIV infection if given pre-exposure prophylaxis (PrEP)[10]; and

Whereas, early detection of HIV allows for initiation of antiretroviral therapy during earlier stages of HIV infection markedly decrease the viral load in the patient, leading to slower disease progression, and possibly preventing progression to Acquired Immunodeficiency Syndrome (AIDS)[11]; therefore be it

RESOLVED, That our AMA amend policy H-50.973, "Blood Donor Deferral Criteria" by addition and deletion, to read as follows:

Blood Donor Deferral Criteria, H-50.973

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation <u>(5) supports referrals for those deemed to be at high risk for HIV transmission to healthcare organizations for testing and treatment.</u>

Fiscal Note: TBD

Date Received: 08/01/2020

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 094
(November 2020)

Introduced by: Danielle Rivera, Sally Midani, University of New Mexico; Rasa Valiauga, Loyola Stritch School of Medicine; Kylee Borger, California University of Science and Medicine; Neha Siddiqui, Carle Illinois College of Medicine; Samantha Pavlock, Florida State University College of Medicine; Syeda Akila Ally, University of Illinois College of Medicine; Ida Vaziri, UT Health San Antonio Long School of Medicine; Kavya Magham, Brianna Diaz, Brooke Byun, WSU Elson S. Floyd College of Medicine; Alyssa Greenwood Francis, Texas Tech University Health Sciences Center El Paso; Arjun Kumar, New York Institute of Technology College of Osteopathic Medicine; Elise Kahn, Medical College of Wisconsin

Sponsored by: Region 1, Region 2, Region 3, Region 4

Subject: Denouncing the use of solitary confinement in correctional facilities and detention centers

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Correctional facilities, which include prisons and jails, are facilities that house people who have been accused and/or convicted of a crime[1]; and

Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees, people awaiting trial or sentence, or young offenders for short periods of time[2]; and

Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual confined to a cell for 22 to 24 hours per day, routinely used as a punishment for disciplinary violations in correctional facilities and detention centers[3]; and

Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as not standing up for headcount or not returning a food tray[3,4]; and

Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means of reprisal for reporting unsafe and unsanitary conditions[5,6];

Whereas, Solitary confinement is distinguished from medical isolation and quarantine because solitary confinement is used punitively while medical isolation is used to reduce the spread of infectious disease[7]; and

Whereas, Solitary confinement consists of extended lengths of social separation, sensory deprivation, and the revocation of prison privileges, while medical isolation is a temporary measure overseen by medical professionals who treat prisoners with compassion and provide prisoners resources to aid their recovery[7]; and

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Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around 60,000 people, currently reside in some form of solitary confinement[8]; and

Whereas, A year in solitary confinement costs three times as much per prisoner, or an average of $75,000 per prisoner per year[9]; and

Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs[10]; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes[11-13]; and

Whereas, There is a strong association between solitary confinement and self harm, for instance, one JAMA study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions[4,13,14]; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders[14]; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality those who do not[15]; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses[16]; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services[12,13]; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement[17]; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism[14,18-20]; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety[19]; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates[20]; and

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Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement[8]; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women[21]; and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18[22,23]; and

Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures[23]; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is “cruel, inhuman or degrading treatment or punishment”[23]; and

Whereas, The Mandela Rules further state that “solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review”[23]; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and should be considered cruel and unusual punishment and a human rights violation[24]; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons[18]; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence[18]; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%[19]; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence[25];

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection[18];

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Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City[26]; and

Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities, and AMA-MSS policy 140.028 opposes the use of solitary confinement for juveniles or the mentally ill regardless of circumstance and opposes the use of solitary confinement for disciplinary purposes; therefore be it

RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows:

> **~~Reducing~~ Opposing the Use of Restrictive Housing in Prisoners ~~with Mental Illness~~ H-430.983**
> Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers; and (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983
Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities. Res. 412, A-18.

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician. Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.

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

Support of Human Rights and Freedom H-65.965

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Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17.

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement. BOT Rep. 24, A-18.

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 095
(November 2020)

Introduced by: Jarrett Campbell, Megan Chiu, Sandra Jones, Indiana University School of Medicine; Jerome Soldo, University of Louisville School of Medicine; Rebecca Anderson, University of Nebraska Medical Center

Sponsored by: Region 2, Region 4, Region 5, Region 6, Region 7

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and Immigration Services (USCIS) are as follows:

1. You must be a U.S. Citizen.
2. If you are unmarried, you must be at least 25 years old.
3. If you are married, you must jointly adopt the child (even if you are separated but not divorced), and your spouse must also be either a U.S. citizen or in legal status in the United States.
4. You must meet certain requirements that will determine your suitability as a prospective adoptive parent, including criminal background checks, fingerprinting, and a home study[1]; and

Whereas, The federal government currently allocates funding for adoption and foster care to states, which independently manage federal funds and have differing statutes concerning eligibility to adopt or place a child up for adoption[2-4,]; and

Whereas, Independent state-licensed child welfare agencies are contracted by each state to provide foster care or adoption services[5]; and

Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how "state-sanctioned discrimination against LGBT individuals who wish to raise children has dramatically increased in recent years"[6-7]; and

Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of children with LGBTQ individuals and same-sex couples and fourteen additional states lack explicit protection for LGBTQ individuals concerning adoption rights[5]; and

Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283 total children in the U.S. foster care system with 125,422 children waiting to be adopted[8]; and

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Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the system[8]; and

Whereas, The longer a child is in foster care, the more likely that child is to move from one foster placement to another, and the greater the risk that child experiences adverse childhood events (ACEs), which may result in lasting negative social and emotional consequences[9]; and

Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster care with no known internal or external problems show an increase in “total problem behavior” in direct correlation with their number of placements[10-12]; and

Whereas, Frequent placement changes result in difficulty forming secure attachments with foster parents, low-self esteem, and a negative relationship with academic growth[10-12]; and

Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential”[13]; and

Whereas, Recent social science literature supports that children living with same-sex parents have equivalent outcomes compared to children with different-sex parents[14]; and

Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to adopt children under age 18 compared to different sex couples[15-16]; and

Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care that addresses the specific health care needs of children in foster care” and supports the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children;” and

Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of their co-parenting partner but does not adequately address adoption rights of LGBTQ individuals nor their limited eligibility or access to adoption, allowing for potential harm towards children by narrowing the pool of qualified foster and adoptive homes; therefore be it

RESOLVED, That our AMA advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation; and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity.

Fiscal Note: TBD

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Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959
The AMA urges: (1) state medical societies to support the **adoption** of a Uniform **Adoption** Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform **Adoption** Act; and (3) state medical societies to support **adoption** of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and **adoption** of children.
Sub. Res. 219, I-93Reaffirmed: BOT Rep. 28, A-03Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based **care** that addresses the specific health **care** needs of children in **foster care**.
Res. 907, I-17

Partner Co-Adoption H-60.940
Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. Res. 204, *A-04Modified: CSAPH Rep. 1, A-14*

Health Care disparities in Same-Sex Partner Households H-65.973
Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.
CSAPH Rep. 1, I-09BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09BOT Rep. 15, A-11Reaffirmed in lieu of Res. 209, A-12

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Adoption H-420.973
It is the policy of the AMA to (1) support the provision of **adoption** information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of **adoption**.
Res. 146, A-90Reaffirmed: Sunset Report, I-00Reaffirmed: CSAPH Rep. 1, A-10

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any **discrimination** based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
*CCB/CLRPD Rep. 3, A-14Reaffirmed in lieu **of**: Res. 001, I-16Reaffirmation: A-17*

Same-Sex and/or Opposite Sex Non-Married Partner 65.009MSS
AMA-MSS will ask the AMA to support legislative and other efforts to allow the adoption by the same-sex and/or opposite sex non-married partner who functions as a second parent or co-parent of children who are born to or adopted by one member.
(MSS Res 24, I-03) (AMA Res 204, A-04 Adopted [H-60.940]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 096
(November 2020)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville.

Sponsored by: Region 2, Region 4

Subject: Amending H-185.947, Insurance Underwriting Reform, to include protections for those who have obtained opioid antagonist medication via prescription or standing order

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Department of Health and Human Services (HHS) states, “an opioid antagonist is used to temporarily reverse the effects of an opioid overdose, namely slowed or stopped breathing”[1]; and

Whereas, The Surgeon General of the U.S. supports increased access to naloxone, while also encouraging everyone possible to get certified in how to use the drug and to carry it with them anywhere they go[1]; and

Whereas, When naloxone and community education are available to community members, overdose deaths decrease in those communities[2]; and

Whereas, Insurance underwriting is the process where an individual or institution takes on financial risk for a fee[3]; and

Whereas, In May 2019, the New York Governor launched an investigation by the Department of Financial Services into claims that nurses were being denied life insurance coverage due to carrying naloxone previously[4]; and

Whereas, In a letter from the New York Deputy Superintendent for Insurance, insurance companies were warned that denying coverage to anyone with a prescription for an opioid reversal drug would be violating state law[5]; and

Whereas, In June 2019, the New Jersey Department of Banking and Insurance issued a bulletin protecting against discrimination in the issuance of life insurance policies for people who have obtained naloxone[6]; and

Whereas, In a bulletin issued by the Massachusetts Commissioner of Insurance, the state established that prescriptions for both opioid reversal drugs and HIV prescription drugs are different than normal prescriptions since they can be used for someone other than the person named to prevent illness[7]; and

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Whereas, In this same bulletin, Massachusetts asked that insurance companies fully investigate all prescriptions and not hold those that do not directly relate to the consumer's health against them[7]; and

Whereas, In a June 2019 notice to Pennsylvania insurers, the state warned that underwriting decisions should not be discriminatory, unfair, or deceptive, and that each case should be carefully considered before making a decision[8]; and

Whereas, Illinois recently introduced a bill (HB4000) that would amend its insurance code to ensure that no one who had received a prescription or obtained an opioid antagonist through standing order would be denied or charged more for life insurance coverage[9]; and

Whereas, In March 2019, the National Council of Insurance Legislators published a resolution that encouraged life insurers not to deny coverage to anyone solely for having a prescription for Narcan[10]; and

Whereas, In a statement released by the National Association of Insurance Commissioners, they expressed their strong desire to protect consumers from unreasonable underwriting practices that deny insurance solely for naloxone use[11];

Whereas, The American Council of Life Insurers (ACLI) released a statement supporting a Massachusetts state law involving opposition to the denial of life insurance and stated its support for not basing coverage in one factor alone[12]; and

Whereas, In both Pennsylvania and Massachusetts bulletins, the states recognize that these insurance policies could have harmful effects on the public health efforts to increase naloxone access[7,8]; and

Whereas, Our AMA has policies that support the availability of naloxone and detail how prescription drug monitoring programs should be used in terms of opioids and naloxone (AMA Policy H-95.922, H-95.932, D-95.987, H-95.947, D-95.980); and

Whereas, The AMA advocates that individuals are not denied insurance for other preventive medications such as PrEP (AMA Policy H-20.895); therefore, be it

RESOLVED, That our AMA amend H-185.947, Insurance Underwriting Reform, to include protections for those who have obtained opioid antagonist medication via prescription or standing order by addition and deletion as follows:

> **Insurance Underwriting Reform, H-185.947**
> Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality; ~~and~~ (3) urges any insurance provider to accept appropriately amended medical records when underwriting decisions require medical record review; and (4) urges insurance companies to not issue any underwriting decision that would deny, limit, or increase the charge for coverage in any way based on prior

or current attainment of an opioid antagonist via prescription or standing order.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals are not denied any insurance on the basis of PrEP use.

Insurance Underwriting Reform H-185.947
Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other

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locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for

education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the
outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies
report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Prescription Drug Monitoring Program Confidentiality H-95.946
Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
A. Institution of comprehensive statewide programs to curtail
prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the
prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students. B. Placement of the prescription drug abuse programs within the context of
other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA:
A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians, so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's-controlled substances database for information on their patients on controlled substances.
3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Naloxone Administration and Heroin Overdose 100.007MSS
AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine.

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

OTC Availability of Naloxone 100.013MSS
Ask the AMA to support the study of OTC availability of Naloxone.

Oppose Tracking of People who Purchase Naloxone 100.025MSS
AMA-MSS will ask the AMA to oppose any policies that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked or monitored by non-healthcare providers

Restrictions on Use of Physician Prescribing Data for Commercial Purposes 120.009MSS
AMA-MSS (1) supports limiting the use of physician prescribing data from any and all sources for commercial purposes, including its use by pharmaceutical companies; and (2) supports the availability of physician prescribing data to organizations using it for public health research, law enforcement, adverse effects reporting, and all other noncommercial purposes.

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 097
(November 2020)

Introduced by: Mahitha Koduri, Tina Reddy, Tulane University School of Medicine; Amaryllis Fernandes, McGovern Medical School at the University of Texas Health Science Center at Houston; Shreya Kondle, University of Texas Southwestern; Meghna Peesapati, Marian University College of Osteopathic Medicine; Bahareh Jabbari, Creighton University School of Medicine.

Sponsored by: Region 2, Region 3, Region 4, Region 5

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, More than 33% of youth entering foster care have a chronic medical condition and up to 80% struggle with significant mental health conditions, requiring sophisticated long-term medical attention well past the age of 18 [1,2]; and

Whereas, Many youths in the foster care system struggle to receive regular health care as they frequently change caregivers and locations, often leading to gaps in their medical and immunization records and poor long term treatment follow through [1]; and

Whereas, Nearly 20,000 children age out of the foster system each year, with the majority leaving with inadequate educational, social and financial support amongst other necessities [3, 4]; and

Whereas, Around 26,000 Former Foster Youth face significant challenges in receiving health care each year [5, 6]; and

Whereas, Children aged out of the foster system are at increased risk for a lifetime of health problems including severe obesity, diabetes, and stroke amongst others due to adverse childhood experiences[7]; and

Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who have aged out of the foster care system in their state until their 26th birthday [8]; and

Whereas, Currently 37 states interpret the law to require Medicaid coverage for 18 to 26-year-old youths who aged out of the foster care system in their own state, not any other state [8 9]; and

Whereas, AMA policy supports comprehensive, evidence-based care only for children currently in foster care (H-60.910); therefore be it

RESOLVED, That our AMA amend H-60.910, by addition to read as follows:

Addressing Healthcare Needs of Children in Foster Care

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Our AMA advocates for comprehensive and evidence-based **care** that addresses the specific health care needs of current and aged-out children in foster care until 26 years of age regardless of which state they aged-out in.

Fiscal Note: TBD

Date Received: 9/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 098
(November 2020)

Introduced by: Jane Anderson, Ryan Wealther, Mary Nunn, and Alexandra Montgomery, UT Health San Antonio; Yomna Amer, University of Louisville School of Medicine

Sponsored by: Region 3

Subject: Supporting the Clear Labeling of Sunscreens

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, the United States Food and Drug Administration (FDA) recommends that consumers use broad spectrum sunscreen with an SPF of 15 or higher, even on cloudy days[1]; and

Whereas, more people are using sunscreens more frequently and in greater quantities than when the FDA initially evaluated sunscreens[2-4]; and

Whereas, sunscreen formulations have changed since their initial evaluation by the FDA[2,5]; and

Whereas, the FDA proposed that there are two sunscreen active ingredients that are generally recognized as safe and effective (GRASE): titanium dioxide and zinc oxide[2,6]; and

Whereas, the FDA proposed that there are twelve sunscreen ingredients that lack safety data to be considered generally recognized as safe and effective[2]; and

Whereas, the FDA proposed cinoxate, dioxybenzone, ensulizole, homosalate, meradimate, octinoxate, octisalate, octocrylene, padimate O, sulisobenzone, oxybenzone, and avobenzone, be deemed as category III, meaning the FDA does not have enough information to make a GRASE determination on these ingredients[7]; and

Whereas, the FDA supports further evaluation of Category III ingredients in order to determine their GRASE status[7]; and

Whereas, the FDA and other investigators have offered scientific evidence of increased plasma concentrations of chemical UV filters, such as avobenzone, oxybenzone, and octisalate, and their metabolites with unknown significance[8,9]; and

Whereas, there is a lack of scientific evidence regarding the long-term consequences of chemical UV filters and their metabolites in terms of carcinogenicity, reproductive effects and developmental effects[8,9]; and

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Whereas, an illustrative example of this is oxybenzone, which has been reported to produce contact and photocontact allergy reactions, implemented as a possible endocrine disruptor, and has been linked to Hirschsprung's disease[10]; and

Whereas, the proposed rule by the FDA on February 26, 2019 on sunscreen drug products for over the counter human use does not include labeling of sunscreen products containing non-GRASE ingredients[7]; and

Whereas, the FDA has reported that a consumer should be able to determine whether or not an over the counter (OTC) product is right for them simply by reading the label[11]; and

Whereas, the American Academy of Dermatology advises consumers that are concerned about certain sunscreen ingredients to select different formulas containing alternative active ingredients[12]; and

Whereas, the American Academy of Pediatrics recommends prioritizing the use of zinc oxide and titanium dioxide, the only two ingredients known to be GRASE[13]; and

Whereas, AMA and AMA-MSS have previously supported clear labeling in other products, including degree of UV protection in sunscreens (Protecting the Public from Dangers of Ultraviolet Radiation: H-440.839), UV protection in sunglasses (Labeling and Recommended Protection for Sunglasses: 440.049MSS), mercury content in foods (Mercury in Food as a Human Health Hazard: 150.013MSS), and warnings on dietary supplements and herbal remedies (Dietary Supplements and Herbal Remedies H-150.954); therefore be it

RESOLVED, That our AMA amend H-440:839, “Protecting the Public from Dangers of Ultraviolet Radiation,” by insertion as follows:

> **Protecting the Public from Dangers of Ultraviolet Radiation, H-440.839**
> SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level. <u>(c) the labeling of sunscreen active ingredients which have not been determined to be generally recognized as safe and effective.</u>

Fiscal Note: TBD

Date Received: 09/20/2020

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2. FDA Advances New Proposed Regulation To Make Sure That Sunscreens Are Safe And Effective. Fda.gov. https://www.fda.gov/news-events/press-announcements/fda-advances-new-proposed-regulation-make-sure-sunscreens-are-safe-and-effective. Updated February 21, 2019. Accessed August 26, 2020.
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RELEVANT AMA AND AMA-MSS POLICY

Permitting Sunscreen in Schools H-440.841

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1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization.
2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

Res. 403, A-13Appended: Res. 422, A-16

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior. TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

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3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.

CCB/CLRPD Rep. 3, A-14Appended: Res. 403, A-14Appended: Res. 404, A-19Appended: Res. 905, I-19

Dietary Supplements and Herbal Remedies H-150.954
1. Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
2. Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.

3. Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements.

4. Our AMA supports that the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims.

5. Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

6. Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

7. Our AMA will continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.

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Res. 513, I-98Reaffirmed: Res. 515, A-99Amended: Res. 501 & Reaffirmation I-99Reaffirmation A-00Reaffirmed: Sub. Res. 516, I-00Modified: Sub. Res. 516, I-00Reaffirmed: Sub. Res. 518, A-04Reaffirmed: Sub. Res. 504, A-05Reaffirmation A-05Reaffirmed in lieu of Res. 520, A-05Reaffirmation I-09Reaffirmed in lieu of Res. 501, A-10Reaffirmation A-11Reaffirmation I-14Modified: Res. 511, A-16Reaffirmation: A-17Reaffirmation: A-19

Food and Drug Administration H-100.980
1. AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible.
2. Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively.

3. Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

Sub. Res. 548, A-92BOT Rep. 32, A-95BOT Rep. 18, A-96Reaffirmed: BOT Rep. 7, I-01Reaffirmation I-07Reaffirmed: Sub. Res. 504, A-10Reaffirmation A-15Reaffirmed: CMS Rep. 06, I-16Reaffirmed: CMS Rep. 07, A-18

Qualitative Labeling of All Drugs H-115.988
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.
Res. 96, A-84Reaffirmed by CLRPD Rep. 3 - I-94BOT Rep. 1, A-95Reaffirmed: CSA Rep. 8, A-05Modified: Sub. Res. 504, A-10Reaffirmation: A-19

National Cosmetics Registry and Regulation H-440.855
1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.

Sunscreen and Sun Protection Counseling by Physicians:
AMA-MSS will ask the AMA to [Our AMA will] encourage physicians to counsel their patients on sub-protective behavior.

(MSS Res 26, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Sunscreen Dispensers in Public Spaces as a Public Health Measure:

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AMA-MSS will ask the AMA to [Our AMA will] support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure.

(MSS Res 28, A-19) (MSS Res. 905, Adopt as Amended [H440.839], I-19)

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

(MSS Res 17, I-14) (Reaffirmed: MSS GC Rep A, I-19)

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

(MSS Sub Res 2, A-15)

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

(MSS Sub Res 34, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products 525.009MSS
AMA- MSS 1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. (MSS Res 27-I-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 099
(November 2020)

Introduced by: Joshua Carrasco & Saraaga Tamirisa, The University of Texas Health at San Antonio Long School of Medicine

Sponsored by: Region 3, Association of Native American Medical Students, GLMA

Subject: Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, 80% of young adults and teenagers learn about sex through primetime television due to its frequent portrayal of sexual information and content[1]; and

Whereas, A content analysis of the top 2015 primetime shows indicated that on average 56% of visual cues and dialogues and 26% of major and minor storylines contained sexual information and content, which primarily portrayed sex as casual, without mentioning contraception, as sexual abuse, and as a means of improving status and for personal gain[1]; and

Whereas, Although themes of sexual orientation and gender identity accounted for 8% of visual cues and dialogues and 20% of major and minor storylines of the top 2015 primetime shows, none of the shows included LGBTQ+ youth relationships or related sexual health information[1]; and

Whereas, Pew Research Center found that 61% of individuals aged 18 to 29 said that “the primary way they watch television now is with streaming services on the internet, compared with 31% who say they mostly watch via a cable or satellite subscription and 5% who mainly watch with a digital antenna”[2]; and

Whereas, A 2017 survey of 750 individuals aged 8 to 21 found that 72% reported their household had a paid Netflix account and 39% reported they had cable/satellite television and 52% of those surveyed viewed television shows streamed on an online streaming service[3]; and

Whereas, The LGBTQ+ community uses television, sexual education courses, self-exploration via geolocation dating apps and “trial and error sexual experiences,” and the Internet to learn about LGBTQ+ inclusive safe sexual practice and sexual health information[4,5]; and

Whereas, A 2017 study by the Guttmacher Institute, a “leading research and policy organization committed to advancing sexual and reproductive health” indicates that only 24 state governments require sex education in school and 34 state governments require human immunodeficiency virus (HIV) education[4]; and

Whereas, In socially conservative states like Oklahoma, sexual education requires same-sex sexual behavior to be emphasized as “less than, deficient, and disease-prone” and directly affiliated with contraction of HIV and Acquired Immunodeficiency Syndrome (AIDS)[4,6]; and

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Whereas, Young men who have sex with men (YMSM) are both less likely to report school-based HIV education and more likely to report sexual risk behaviors, including condomless sex and three or more sexual partners in the last three months, compared to young men who have sex with women[7]; and

Whereas, The 2019 National Youth Risk Behavior Survey (YRBS) reports that among high-school students, students who have sex with same-sex partners or partners of both sexes are more likely to have four or more lifetime sexual partners compared to students who only have sex with opposite-sex partners[8]; and

Whereas, The 2019 YRBS reports that among sexually active high school students, students who have sex with same-sex partners or partners of both sexes are less likely to have used a condom during their last sexual encounter[8]; and

Whereas, A 2016 study showed a correlation between the use of geolocation dating and other various social media apps with participation in sexual practices that put YMSM and trans individuals at higher risk for contracting HIV, including “seeking partners online, exchanging sex for money/clothes, and exchanging sex for drugs[9];

Whereas, This same study reported that current evidence-based non-social media HIV prevention programs were not reaching these LGBTQ+ youth, and that targeted social media interventions may be more beneficial in reaching them[9]; and

Whereas, Individuals aged 13 to 24 made up 21% of new HIV diagnoses in 2018[10]; and

Whereas, Male-to-male sexual contact attributed 92% of the new HIV diagnoses in 2018[10]; and

Whereas, A study evaluating an online sexual health promotion program for LGBTQ+ youth showed that the internet and social media are feasible, effective, and inexpensive tools to disseminate comprehensive LGBTQ+ inclusive sexual health information[11]; and

Whereas, This same study showed the greatest increase in “knowledge of sexual functioning, HIV and STIs, and contraceptives” among participants[11]; and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of LGBTQ+ inclusive sex education including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968, but falls short of underscoring the importance of LGBTQ+ inclusive sex education in television broadcasts, online streaming services, and any associated social media outlets; and

Whereas, The AMA policy Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994 currently recognizes the benefit of utilizing accessible platforms like television as a means of educating individuals about sexual health, but falls short of advocating for the inclusion of LGBTQ+ specific safe sexual practices on wider platforms like online streaming services and associated social media; therefore be it

RESOLVED, That our AMA amend policy H-485.994, “Television Broadcast of Sexual Encounters and Public Health Awareness” by addition and deletion, to read as follows:

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Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994

The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994
The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex. Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

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(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

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

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

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who

identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

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

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.

(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.

(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.

(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.

(8) Information on health and health care should be presented in an accurate and objective manner.

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(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.

(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.

(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs. BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15; Reaffirmed: BOT Rep. 15, A-19

Sexually Oriented Advertising to Youth H-60.989
The AMA (1) endorses the idea that advertising campaigns can present youth in positive settings that promote healthy lifestyles and themes for youth to emulate, while presenting products for consideration without relying on sexual themes;
(2) encourages advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines, especially in teen-oriented publications, that would refrain from the intentional association of suggestive and stimulating sexual messages in product advertising; and
(3) supports continued research regarding the health effects of sexual themes in the media on youth. Res.169, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Routine HIV Screening D-20.992
Our AMA:
(1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 and sexually active adults over 65, (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening;
(2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience;

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(3) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings;
(4) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings;
(5) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers;
(6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and
(7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations. CSAPH Rep. 2, I-06; Modified: Res. 927, I-10; Reaffirmation I-13

National HIV Testing Day 20.015MSS
AMA-MSS will ask the AMA to recognize National HIV Testing Day and encourage AMA members to promote participation in voluntary HIV testing and counseling through community and media outreach, health fairs, and free testing sites across the country. MSS Res 20, I-05; AMA Res 516, A-06 Adopted [H-20.904]; Reaffirmed: MSS GC Rep F, I10; Reaffirmed: MSS GC Rep D, I-15

Contraceptive Programming in the Media 75.003MSS
AMA-MSS will ask the AMA to urge print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness. AMA Res 114, I-86 Adopted [H75.996]; Reaffirmed: MSS Rep E, I-96; Reaffirmed: MSS Rep B, I-01; Reaffirmed: MSS Rep F, I-06; Reaffirmed: MSS GC Rep D, I-11; Reaffirmed: MSS GC Report A, I-16

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 100
(November 2020)

Introduced by: David Long, Tulane University; Amaryllis Fernandes, UTH McGovern Medical School

Sponsored by: N/A

Subject: Recognizing Misinformation as a Public Health Issue

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Social media platforms have an extensive reach, helping to educate and spread important information to a large portion of the public[1]; and

Whereas, The World Health Organization states we are facing an "infodemic," with an overabundance and wide dissemination of sensational information that may or may not be accurate[2]; and

Whereas, Conspiracy theories and misinformation can spread rapidly through social media[3] and lead to widespread rejection of more complete and accurate scientific evidence, normalizing distrust in healthcare and public institutions[4,5]; and

Whereas, Exposure to misinformation through online social networks is associated with poorer vaccination rates and other socioeconomic measures[6], including adherence to recommended COVID-19 precautions[7,8]; and

Whereas, Specific social media accounts are often created for the explicit purpose of spreading misinformation,[9] and rely on low media literacy, and time and technological barriers to verification of information to avoid detection; and

Whereas, Conspiracy theories are most effectively stopped by trusted authority figures speaking out against the conspiracies and falsehoods[,11,12]; and

Whereas, At a time when trust in government actions related to COVID-19 remains low[13], 74% of Americans have a positive view of medical doctors, and doctors hold power to combat the spread of misinformation and sway public opinion[14,15]; and

Whereas, Although rumors and conspiracies are not new, their spread via the new medium of online platforms presents new challenges[16] that are not adequately addressed by existing AMA policy; therefore be it

RESOLVED, That Our AMA define misinformation as, "any publicly disseminated false or inaccurate information that has significant potential to deceive the public and/or cause public harm if propagated or widely believed"; and be it further

RESOLVED, That Our AMA reaffirm policies H-445.995 and H-445.998.

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Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Responses to News Reports and Articles H-445.995

Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues.

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

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(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

Propriety of Professional Public Communications H-445.998

Our AMA encourages: (1) the initiative of those physicians who desire to speak out as individuals, on public issues; and (2) all authorized spokesmen for component societies to participate in local, state and national issues as responsible physicians in order that the voice of organized medicine be heard.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 101
(November 2020)

Introduced by: Bahareh Jabbari, Alvina Le, Hannah Meissner; Kevin Brittan, Steven Graefe, Jenna Heil, Sean DeLeon, Alex Johar, Ayushi Sharma, Kari Stauss, Elise Tidwell, Sarah Westbrook, Steven Yackley; Creighton University School of Medicine

Sponsored by: N/A

Subject: Proactive Defense of Cybersecurity Threats

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Hospitals are routinely the victims of data breaches[1]; and

Whereas, Healthcare data breaches have impacted records totaling 69.78% of the United States' population[1]; and

Whereas, Healthcare data is more valuable than other data due to the ability to utilize credentials for health services or prescription medications[2]; and

Whereas, Cyberattacks could cost the US health care system $305 billion over the course of 5 years[3]; and

Whereas Personal medical devices such as pacemakers and respirators, which were traditionally stand-alone systems, are becoming network-integrated within hospital IT systems and are becoming more valuable targets for cybercriminals[4]; and

Whereas Such personal medical devices, if tampered by a cybercriminal, would inhibit telemonitoring of patients' conditions and potentially induce inappropriate functioning from these medical devices (e.g., inappropriate pacemaker activation)[5]; and

Whereas, 51% of healthcare cybersecurity threats target imaging devices which affect quality of patient care[6]; and

Whereas, A 2018 PWC report found that 95% of provider executives believe "their practice is secure against cybersecurity threats"[7]; and

Whereas, In reality only "36% of providers and payers have access management policies in place, and 34% have a cybersecurity audit process in place"[7]; and

Whereas, An estimated 83% of currently used medical imaging devices are ran on outdated operating systems[6]; and

Whereas, Federal initiatives are allocating 95% of their IT budget on implementation and only less than 5% on IT security[8]; and

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Whereas, In terms of cybersecurity, the healthcare industry is lagging behind other leading industries[5]; and

Whereas, The main purpose of Identity and Access Management (IAM) systems is to allow authorized users access to necessary data and deny access to unauthorized users[9]; and

Whereas, IAM systems can be used to ensure security by authenticating users, devices or services and controlling access to resources based on pre-established policies[10]; and

Whereas, Even the Department of Defense intends to implement access management infrastructure as a part of their information technology modernization strategy[11]; and

Whereas, Internal cybersecurity audits are considered an integral part of cybersecurity[12]; and

Whereas The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), enforced by the United States Department of Health and Human Services, promotes the development and standardization of a nationally interoperable EHR with stronger cybersecurity practices compliant with HIPAA[8]; and

Whereas, Cybersecurity breaches have the potential to reduce patient trust, weaken health systems and put patients' lives at risk, it is important for hospitals to take preventative measures and ensure patient safety[13]; and

Whereas, This is a serious issue that must be addressed sooner rather than later; therefore be it

RESOLVED, That our AMA encourages hospitals to prioritize cybersecurity to improve patient care, quality, and safety, and be it further

RESOLVED, That our AMA encourages hospitals to prioritize cybersecurity to prevent hospitals from experiencing monetary loss and decrease time and resources spent on responding to attacks; and be it further

RESOLVED, That our AMA encourages hospitals to create access management policies, cybersecurity audit processes, and any future cybersecurity defense systems.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Breach of Security in Electronic Medical Records

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When used with appropriate attention to security, electronic medical records (EMRs) promise numerous benefits for quality clinical care and health-related research. However, when a security breach occurs, patients may face physical, emotional, and dignitary harms.

Dedication to upholding trust in the patient-physician relationship, to preventing harms to patients, and to respecting patients' privacy and autonomy create responsibilities for individual physicians, medical practices, and health care institutions when patient information is inappropriately disclosed.

The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on his or her awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.

When there is reason to believe that patients' confidentiality has been compromised by a breach of the electronic medical record, physicians should:

(a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose.

(b) Follow all applicable state and federal laws regarding disclosure.

Physicians have a responsibility to follow ethically appropriate procedures for disclosure, which should at minimum include:

(c) Carrying out the disclosure confidentially and within a time frame that provides patients ample opportunity to take steps to minimize potential adverse consequences.

(d) Describing what information was breached; how the breach happened; what the consequences may be; what corrective actions have been taken by the physician, practice, or institution; and what steps patients themselves might take to minimize adverse consequences.

(e) Supporting responses to security breaches that place the interests of patients above those of the physician, medical practice, or institution.

(f) Providing information to patients to enable them to mitigate potential adverse consequences of inappropriate disclosure of their personal health information to the extent possible.

Integration of Mobile Health Applications and Devices into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates

team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and **security** of patients' medical information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and **security** of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and **security** laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and **security** risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

The Computer-Based Patient Record H-480.971

The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction (the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on

the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic medical data control, access, **security**, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and **security** of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record.

Electronic Data Interchange Status Report H-315.979

Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

Confidentiality of Computerized Patient Records H-315.989

The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.

Guidelines for Patient-Physician Electronic Mail and Text Messaging H-478.997

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.

(b) Inform patient about privacy issues.

(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.

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(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.

(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.

(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.

(g) Request that patients put their name and patient identification number in the body of the message.

(h) Configure automatic reply to acknowledge receipt of messages.

(i) Send a new message to inform patient of completion of request.

(j) Request that patients use autoreply feature to acknowledge reading clinicians message.

(k) Develop archival and retrieval mechanisms.

(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.

(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.

(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about **security** and the importance of alternative forms of communication for emergencies.

(o) Explain to patients that their messages should be concise.

(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.

(q) Remind patients when they do not adhere to the guidelines.

(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

(b)Terms in communication guidelines (stated above).

(c) Provide instructions for when and how to convert to phone calls and office visits.

(d) Describe **security** mechanisms in place.

(e) Hold harmless the health care institution for information loss due to technical failures.

(f) Waive encryption requirement, if any, at patient's insistence.

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(g) Describe **security** mechanisms in place including:

(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.

(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.

(j) Never using patient's e-mail address in a marketing scheme.

(k) Not sharing professional e-mail accounts with family members.

(l) Not using unencrypted wireless communications with patient-identifiable information.

(m) Double-checking all "To" fields prior to sending messages.

(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.

(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.

Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973

1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:

a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.

b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and **Security** Rules.

c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.

d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.

e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.

f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.

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g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.

h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.

2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:

a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the **security** or integrity and unauthorized uses or disclosure of the information.

b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.

d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

3.3.2 Confidentiality & Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;

(ii) capacity to routinely monitor/audit access to records;

(iii) measures to ensure data **security** and integrity; and

(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality.

Augmented Intelligence in HealthCare H-480.940

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As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;

b. is transparent;

c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and

e. safeguards patients' and other individuals' privacy interests and preserves the **security** and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977

Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of **security** compromises.

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate

standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

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8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

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13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Patient Information in the Electronic Medical Record H-315.971

AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

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(1) Online interactions are best conducted over a secure network, with provisions for privacy and **security**, including encryption.

(2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known. (c) Keep a written record, electronic or paper, of each patient authenticated.

(3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.

(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.

(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.

315.006MSS Improving Cybersecurity in Healthcare Facilities

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AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 102
(November 2020)

Introduced by: Danielle Rivera, University of New Mexico; Kimberly Lau, California Northstate University COM; Rowena Hann, Touro University

Sponsored by: Region 1, Region 2, Region 4

Subject: Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Correctional facilities frequently require medications to treat their inmates' mental health conditions[1,2]; and

Whereas, Medications used for mental health conditions are some of the most highly marketed and lucrative medications[3]; and

Whereas, Depending on the healthcare model of the correctional facility, only a handful of correctional facility administrators control the decision of which medications are available for inmates and negotiate directly with the drug supplier, either pharmaceutical companies or a single, contracted vendor[2]; and

Whereas, While physicians prescribe medications to inmates, their prescribing behavior is restricted by wardens, sheriffs, and prison administrators who negotiate the formulary with pharmaceutical companies[2];

Whereas, Judges also limit physicians' prescribing behavior when they order a prisoner to receive medication against a prisoner's wishes, require specific medications in order to be released, or will only release prisoners to treatment centers that manage opioid use disorder with the medication the judge prefers[4,5]; and

Whereas, The requirement of specific medications to secure release can result in coercion[4]; and

Whereas, Pharmaceutical companies have begun marketing medications, particularly mental health medications, to these controlling parties: judges, wardens, and sheriffs who work in the judicial system and in correctional facilities[4,5]; and

Whereas, A company trying to improve sales of Naltrexone, an opiate antagonist used to manage opioid use disorder, spread false information by comparing it favorably to Suboxone, a cheaper drug with significantly more research on its efficacy, leading to its adoption in correctional facilities across the country and in patient management post-incarceration[4,5]; and

Whereas, The practice of marketing through offering small gifts, free samples and other inducements is known as "detailing," a practice some states have banned outright[1]; and

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Whereas, Researchers at Yale and Columbia analyzed a data set of over 189 million psychotropic medication prescriptions across the country and found that physicians in states with detailing bans were between 39%-83% less likely to prescribe new medications, more likely use generic medications, and more likely to rely on other physicians rather than pharmaceutical marking for medication recommendations[1]; and

Whereas, Another study found that doctors who received money from a pharmaceutical company would prescribe more of that company's drugs[6]; and

Whereas, Our AMA's Code of Medical Ethics Opinion 9.6.2 discourages doctors from receiving gifts from medical supply companies due to the potential for perverse incentives; and
Whereas, Pharmaceutical marketing to non-medical professionals can result in non-evidence-based medicine selections that may be less efficacious and also lead to increased costs for the taxpayer-supported prison healthcare system[6,7,8]; and

Whereas, Current AMA policy H-100.955 calls for the use of evidence-based practices in drug courts but does not address the marketing incentives that make evidence-based practices more difficult, nor does it address medical decisions made on behalf of prisoners outside of drug court; therefore be it

RESOLVED, That our AMA will actively oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, and other detention administrators; and be it further

RESOLVED, That our AMA will advocate for the inclusion of physicians in the selection and negotiation of which drugs are available to vulnerable populations such as inmates; and be it further

RESOLVED, That our AMA will work with state legislatures and their respective Departments of Corrections to adopt transparency-increasing measures, including, but not limited to, (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a *de minimis* amount, and (2) centralizing formulary choices, to the extent they are not already, in a physician-led office, agency, or commission.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder,

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or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.

5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

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6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.

12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.

13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs. BOT Rep 38 and Sub Res 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19

Pharmaceutical Advertising in Electronic Health Record Systems D-478.961
Our AMA: (1) encourages the federal government to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems

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(EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices; and (2) will study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. Res 207, I-19

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. Res 201, A-12; Appended: BOT Rep 09, I-19

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;

(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion. Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00Reaffirmation I-09Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16 Appended: Res. 421, A-19 Appended: Res. 426, A-19

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.

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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.

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

9.6.2 Gifts to Physicians from Industry

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Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.
Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.
To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations.

(b) Decline any gifts for which reciprocity is expected or implied.

(c) Accept an in-kind gift for the physician's practice only when the gift:
(i) will directly benefit patients, including patient education; and
(ii) is of minimal value.

(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:
(i) the program identifies recipients based on independent institutional criteria; and
(ii) funds are distributed to recipients without specific attribution to sponsors.
Issued: 2016

9.7.2 Court-Initiated Medical Treatment in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians

not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given. Issued: 2016.

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

Pharmaceutical Advertising in Electronic Health Record Systems 150.004MSS
AMA-MSS will ask the AMA to 1) encourage the Center for Medicare and Medicaid Services to study the effects of direct-to- physician advertising at the point of care, including advertising in EHRs, on physician prescribing, patient safety, health care costs, and EHR access for small practices; and 2) study the ethics of direct to physician advertising at the point of care, including advertising in electronic health record systems. MSS CHIT/CEQM Rep A, A-19; AMA Res. 207, Adopt as Amended [D-478.961], I-19

Drug Pricing Reform 100.014MSS
AMA-MSS will ask the AMA to oppose the promotion of drugs in the absence of reasonable evidence for claims made. (AMA Res 132, A-83, Referred) (BOT Rep KK, A-83, Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 103
(November 2020)

Introduced by: Sachin Mishra, Will Collins, Amrutha Doniparthi, University of Arizona College of Medicine - Tucson

Sponsored by: N/A

Subject: Improving the quality of school provided meals through local produce supplementation

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Farm to School programs encompass school- based nutrition education through local fruit and vegetable supplementation of school lunches and/or farm visits, school gardening, or experiential education[1] ; and

Whereas, Agriculture experiential learning helps students perform better in the classroom and helps them think broadly about science and the food system[1] ; and

Whereas, When combined with educational curricular support, Farm to School programs have been found to lead to increased intake of fruits and vegetables following inclusion of local produce, with a positive effect on at-home consumption of fruits and vegetables[2] ; and

Whereas, Local produce generally has a higher nutritional content than out-of-state produce[2,3]; and

Whereas, Improved access to healthy foods is associated with healthier diet choices[,2,3]; and

Whereas, State laws requiring or/encouraging Farm to School Program were significantly associated with increased fresh produce availability in schools, with some districts reaching up to 70.6% school participation within the program[4], and

Whereas, Public school food procurement rules favor large corporate firms. In addition to schools incurring extra administrative cost, both the school and the local farmer often lack the requisite equipment to make small-volume local food supplementation efficient, such as food storage and preparation facilities[2,5,6,7]; and

Whereas, AMA policies H-150.944, H-150.937, H-150.962 and 150.020MSS all contain language supporting the expansion of existing nutritional food assistance programs, but lack an actionable way to make these positions a reality; therefore be it

RESOLVED, That our AMA work with state education and agriculture departments to create streamlined and equitable food safety regulations and certification requirements for local farmers to reduce the disproportionate; and it be further

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RESOLVED, That our AMA encourages the USDA and state agriculture departments to enhance or add new spaces for food hubs, databases or cooperatives for small farmers and producers to interact with each other and the general public in order to help them become more competitive with corporate or national foodservice companies.

Fiscal Note: TBD

Date Received: 09/20/2020

References:

1. Blair, D. (2009). The Child in the Garden: An Evaluative Review of the Benefits of School Gardening. *The Journal of Environmental Education, 40*(2), 15-38.
2. Harris D., Megan Lott, Velma Lakins, Brian Bowden, Joel Kimmons, Farm to Institution: Creating Access to Healthy Local and Regional Foods, *Advances in Nutrition*, Volume 3, Issue 3, May 2012, Pages 343–349.
3. Conner, D. S., Izumi, B. T., Liquori, T., & Hamm, M. W. (2012). Sustainable school food procurement in large K-12 districts: Prospects for value chain partnerships. *Agricultural and Resource Economics Review, 41*(1), 100-113.
4. Haynes-Maslow, L., & O'Hara, J. (2015). *Lessons from the Lunchroom: Childhood Obesity, School Lunch, and the Way to a Healthier Future*
5. Christensen LO, Jablonski BBR, O'hara JK. School districts and their local food supply chains. *Renewable Agriculture and Food Systems*. 2017;34(03):207-215. doi:10.1017/s1742170517000540.
6. Thompson JJ, Brawner AJ, Kaila U. “You can’t manage with your heart”: risk and responsibility in farm to school food safety. *Agriculture and Human Values*. 2017;34(3):683-699. doi:10.1007/s10460-016-9766-4.
7. Qu, S., Fischer, L., & Rumble, J. N. (2019). Building bridges between producers and schools: The role of extension in the Farm-to-School program. *Journal of Extension*, 57(4). Article 4FEA4, https://joe.org/joe/2019august/a4.php.

Relevant AMA and AMA-MSS Policy

Reduction in Consumption of Processed Meats H-150.922

1. Our AMA supports reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer.
2. Our AMA supports initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition.
3. Our AMA supports public awareness of the risks of processed meat consumption.
4. Our AMA supports educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

Res. 406, A-19

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932

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1. Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.

Res. 215, A-13

Improvements to Supplement Nutrition Programs H-150.937

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

Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Combating Obesity and Health Disparities H-150.944

1. Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugar, and cholesterol.

Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

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Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960

1. Our AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

Nutritional Education H-150.996

1. Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools.

Sub. Res. 66, I-77; Reaffirmed CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00

Prevention of Obesity Through Instruction in Public Schools H-170.961

1. Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort.

Res. 426, A-12

Decreasing Incidence of Obesity and Negative Sequelae by Reducing Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods: 150.020MSS

AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased

funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC.

(MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, 1-19)

Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs: 150.029MSS

AMA-MSS will ask the AMA to support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors. (MSS Res 12, I-14) (Existing Policy Reaffirmed in Lieu of AMA Res 405, A-15) (Reaffirmed: MSS GC Rep A, I-19)

Defending Federal Child Nutrition Programs: 150.032MSS

AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirms H-150.962 Quality of School Lunch Program.

MSS Res 09, A-17

Identifying and Addressing Food Insecurity and Food Deserts Nationwide: 150.034MSS

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

MSS Res 46, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 104
(November 2020)

Introduced by: Lauren Miller, Medical College of Wisconsin; Zoe Moyer, Virginia Commonwealth University School of Medicine; Emily Frech, Samira Ali, University of Oklahoma College of Medicine; Melissa Chan, University of Iowa; Jami Wang, Western University of Health Sciences; Julia Seiberling, University of California Riverside

Sponsored by: Region 2

Subject: Sexual Harassment Accreditation Standards for Medical Training Programs

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Sexual harassment is defined as “sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (l) such conduct interferes with an individual’s work or academic performance or creates an intimidating, hostile, or offensive work or academic environment or (2) accepting or rejecting such conduct affects or may be perceived to affect employment decisions or academic evaluations concerning the individual” by the AMA Journal of Ethics and is “unethical…[and] raise[s] concerns because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees and may adversely affect patient care”[1]; and

Whereas, According to the 2018 report from the National Academies of Sciences, Engineering, and Medicine, 49.6% of female students in medical school or in graduate school for a healthcare field have reported having experienced sexual harassment during their training[2]; and

Whereas, Female medical students are 220% more likely to experience unwanted crude behavior from faculty or staff compared to female students studying non-scientific fields[2]; and

Whereas, At one medical program, female medical students were more likely than their male colleagues to be physically sexually harassed and to be harassed by a person of higher professional status, resulting in 79% of female survivors and 45% of male survivors saying that the experience of sexual harassment created a “hostile environment” or interfered with work performance[3]; and

Whereas, Sexual harassment during training has been shown to have a significant impact on the specialty and residency program choices of female trainees[4]; and

Whereas, Female residents are more likely to experience sexual harassment during graduate medical education in fields such as surgery and emergency medicine compared to other specialties, with one study finding that 70.8% of female general surgery residents reported experiencing sexual harassment during training[2,5]; and

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Whereas, Female residents are more likely to experience sexual harassment in male-dominated workplaces, especially when leadership is male-dominated, and male physicians continue to be dramatically overrepresented in healthcare leadership positions, with 84% to 85% of department chair and medical dean appointments in 2013 to 2014, despite approximately equal female entrance into medicine[2,6-9]; and

Whereas, Experiencing sexual harassment has been linked to poor job-related outcomes such as work withdrawal, a decrease in commitment to the organization, and reduction of job satisfaction, and sexual harassment has a stronger negative impact on a woman's well-being through psychological consequences such as anxiety and depression compared to general job stressors such as workload and meeting deadlines[2,10]; and

Whereas, Sexual harassment continues to be a problem in medicine despite federal protection such as Title VII, Title IX, and the Clery Act, which intend to protect victims of sexual harassment from gender discrimination and unwanted sexual attention[11-14]; and

Whereas, Under Title IX, educational institutions are required to provide students and trainees with resources for reporting sexual harassment, including information on their rights under Title IX, how to contact the institution's Title IX coordinator, and how to file a complaint of sexual harassment, and the institution must also have a policy how it will investigate and respond to reported allegations of sexual harassment[15]; and

Whereas, Legal protections do not adequately protect trainees from covert retaliation, and fear of retaliation accounts for 28% of the approximately 79% of cases of sexual harassment that go unreported[11]; and

Whereas, In the absence of an institutional culture that promotes sexual harassment training at all levels and the importance of incident reporting as part of the solution to mitigate sexual harassment, sexual harassment training and reporting methods are not effective at reducing sexual harassment of medical trainees[16-18]; and

Whereas, A recent survey of pediatric, gastroenterology, and internal medicine residents revealed that only 43% knew of institutional policies to support sexual harassment victims and a 2017 AAMC survey of medical students found that only 21% of students reported experiences of sexual harassment, with 37% of those not reporting stating "I did not think anything would be done about it" and 9% of those not reporting stating "I did not know what to do"[11,19]; and

Whereas, The Liaison Committee on Medical Education (LCME) serves as the accrediting body that holds all medical schools to 12 standards which ensure graduates have been adequately trained to begin graduate medical education[20]; and

Whereas, The LCME does not explicitly address sexual harassment in the written standards for Anti-Discrimination, and Student Mistreatment[21]; and

Whereas, The LCME Standard 12 does explicitly address the need for medical schools to provide "effective student services to all medical students to assist them in achieving the program's goals for its students"[21]; and

Whereas, The LCME Standard 12.3: Personal Counseling/Well-Being Programs states that "A medical school has in place an effective system of personal counseling for its medical students

that includes programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education," thereby establishing precedent for specific standards on student well-being including for the concerns addressed herein[21]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) serves as the accrediting body that evaluates all residency and fellowship programs to ensure programs meet the established quality standards for each specialty and subspecialty[22]; and

Whereas, The ACGME requires residency and fellowship programs to maintain a professional environment free from sexual harassment, but does not explicitly state how that standard is evaluated[23,24]; therefore be it

RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation that addresses sexual harassment in medical education; and be it further

RESOLVED, That our AMA encourage the LCME and ACGME to investigate 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings, and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY
9.1.3 Sexual Harassment in the Practice of Medicine
Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII
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

Principles for Advancing Gender Equity in Medicine H-65.961
Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
BOT Rep. 27, A-19

Policy on Conduct at AMA Meetings and Events H-140.837
It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex,

sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines
The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)
The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy
Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations
All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action
If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety

of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality
All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy
As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at https://www.lighthouse-services.com/ama. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]
BOT Rep. 23, A-17 Appended: BOT Rep. 20, A-18 Modified: BOT Rep. 10, A-19

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References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment G-600.067
Our AMA will: (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; (3) present the preliminary study results to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and (4) produce a report within 18 months with study results and recommendations.
Res. 009, A-19

Proposed Consolidation of Liaison Committee on Medical Education H-295.882
(1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education.

(2). Our AMA supports a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding.

(3) Consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree.

(4) The LCME will have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME.

(5) A new entity will be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding.

(6) The AMA Council on Medical Education will be the entity within the AMA to determine policy relating to the organization or structure of the LCME.
CME Rep. 7, A-03 Modified and Appended: BOT Rep. 16, A-12

Broadly Based Clinical Experience and Clinical Proficiency Standards H-295.960
It is the policy of the AMA: (1) to direct its representatives on the LCME to continue to monitor the educational content of the final year of educational programs accredited by the LCME so that the standards, and their application to accredited programs, will provide a broad clinical experience; and (2) to reaffirm existing policy that the first year of graduate medical education should provide the resident physician with a broad clinical experience.
CME Rep. H, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10

Medical School Honor Codes H-295.966
Our AMA urges the LCME to facilitate the development of honor codes by medical schools.
CME Rep. D, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10

Teacher-Learner Relationship In Medical Education H-295.955

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The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

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While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
BOT Rep. ZZ, I-90 Reaffirmed by CME Rep. 9, A-98 Reaffirmed: CME Rep. 2, I-99 Modified: BOT Rep. 11, A-07 Reaffirmed: CME Rep. 9, A-13

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

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(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

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(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

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(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality

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and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.
CME Rep. B, A-82 Amended: CLRPD Rep. A, I-92 Res. 331, I-95 Reaffirmed by Res. 322, A-97 Reaffirmation I-03 Modified: CME Rep. 7, A-05 Modified: CME Rep. 2, I-05 Appended: CME Rep. 5, A-11 Reaffirmed: CME Rep. 3, A-11 Modified: CME Rep. 01, I-17 Appended: Res. 961, I-18

Enforcement of ACGME Requirements D-310.995
(1) The ACGME be asked to distribute the alternatives suggested in this report to each of the Residency Review Committees (RRC) and the Institutional Review Committee for their consideration and comment as mechanisms to enforce compliance with requirements.

(2) Our AMA representatives be requested to ask the ACGME and the RRCs to discuss mechanisms included in this report to enhance the enforcement of Institutional and Program Requirements without increasing the risk of the withdrawal of accreditation.

(3) Our AMA representatives be requested to ask the ACGME and the RRCs to determine any additional information regarding program evaluations that can be added to the ACGME web site and that they encourage the ACGME to simplify that web site to facilitate the retrieval of information.

(4) Our AMA, through the Medical Student Section and the Resident and Fellow Section, will provide medical students and residents a guide to interpreting the ACGME Web site as it relates to the various levels of accreditation and the length of the survey cycle.
CME Rep. 3, A-00 Reaffirmed: CME Rep. 2, A-10

Alignment of Accreditation Across the Medical Education Continuum H-295.862
1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.

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c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
CME Rep. 4, A-14 Appended: CME Rep. 10, A-15

630.029MSS AMA Resource Libraries in Medical Schools: AMA-MSS urges its school delegates to obtain reserve space in their schools' medical libraries to set up an AMA library that would include, but not be limited to, the following documents: the AMA Policy Compendium; the state society Policy Compendium (where available); the most current AMA-HOD Proceedings; the most current AMA-MSS Proceedings; the AMA-MSS Textbook of Legislation; the AMA- MSS Resource Manual; the AMA-MSS Internal Policy and Digest of Actions; Chapter Bylaws; AMA-MSS Policy Documents (e.g. "Sexual Harassment Guidelines"); available national, state, regional, and county society updates and newsletters of at least the immediate past year; and AMA-MSS Program Modules. (MSS Sub Res 20, I-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.123MSS Teaching and Evaluating Professionalism in Medical Schools: AMA-MSS will ask the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME- accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation

process, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME-accredited medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations. (MSS Res 10, A-04) (AMA Amended Res 304, A-05 Adopted [D-295.954]) (Reaffirmed: MSS GC Report B, I-09) (D-295.954 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16)

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

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

Required Clinical Skills Assessment During Medical School D-295.988
Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills., and 2) require that medical students attending LCME-accredited institutions pass a school- administered clinical skills examination to graduate from medical school.; and (3) ask that our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME- accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams.
(MSS Res 01, A-16 Immediate Transmittal) (AMA Res 321, A-16 Alternate Resolution 311, A-16 Adopted as Amended in Lieu of Res 311, 316, 317, and 321 [ ])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 105
(November 2020)

Introduced by: Spandana Mandaloju and Chloe Denham, University of Texas-McGovern Medical School

Sponsored by: N/A

Subject: Incorporating human trafficking education into the medical school curriculum.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The United States Department of Justice defines human trafficking as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age" or "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery[1];" and

Whereas, An estimated 100,000 to 300,000 adolescents are at risk for being trafficked in the United States annually[2], and traffickers target the most vulnerable of populations, including females (94%)[2], children (33%)[3], and transgender individuals[2,3]; and

Whereas, Ultimately, approximately 87% of victims come into contact with health care professionals, giving health care providers the unique opportunity to identify and help these individuals[5]; and

Whereas, Most trafficked victims present to the emergency department (63%) but also to other outpatient clinics (35%) with health issues including but not limited to sexually transmitted diseases, human immunodeficiency virus/acquired immunodeficiency syndrome, pregnancy, injuries from physical and/or sexual assault, post-traumatic stress disorder, and depression[2]; and

Whereas, It is rare for trafficking victims to disclose their victimization to health care providers due to their traffickers' manipulative and exploitative techniques[2], making it particularly difficult for physicians to recognize patients as victims; and

Whereas, Most medical trainees place importance on knowing about human trafficking, but they lack knowledge of the national statistics regarding the sex trafficking of minors and knowledge of appropriate responses to encountering a trafficked victim compared to practicing physicians[5]; and

Whereas, The American College of Obstetrics and Gynecology, the American Medical Women's Association, and the American College of Emergency Physicians have recommended their members increase their awareness of human trafficking and be prepared to recognize indicators of human trafficking[6-8]; and

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Whereas, There is wide consensus that education on sex and human trafficking should be included in medical curriculum, but limited published educational resources exist on best practice recommendations for medical student education on sex trafficking[9-11]; and

Whereas, Medical Students have gaps in their ability to handle complex encounters with human trafficking, and consolidating curriculum recommendations on human trafficking could improve victim identification and treatment[9-11]; and

Whereas, Medical schools that integrated simulation-based medical education on human trafficking and trauma-informed care into the third year of medical school found that students were more confident in identifying physical exam findings that indicated human trafficking [9,12]; and

Whereas, Existing AMA policy (H-65.966) encourages physicians to become educated on identifying and serving human trafficking victims, but this policy is not extended to medical students; therefore be it

RESOLVED, That our AMA amend policy H-65.966, Physicians Response to Victims of Human Trafficking, to increase medical student competency in identifying human trafficking victims by addition as follows:

Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals

b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

3. Our AMA encourage medical schools to include human trafficking awareness within the medical school curriculum, including but not limited to education on screening, intervention, and providing resources for victims.

4. Our AMA will collaborate with subject matter experts to determine best practice recommendations on human trafficking education that will be developed and made available as a prototype curriculum for use in all levels of training.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Physicians Response to Victims of Human Trafficking H-65.966
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a. An assessment tool for health care professionals
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The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs. BOT Rep. 20, A-13; Appended: Res. 313, A-15

Code of Medical Ethics: 8.10 Preventing, Identifying, and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect

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their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients' well-being, physicians individually should:

(a) Become familiar with: (i) how to detect violence or abuse, including cultural variations in response to abuse; (ii) community and health resources available to abused or vulnerable persons; (iii) public health measures that are effective in preventing violence and abuse; (iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should: (i) inform patients about requirements to report; (ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

The Identification and Protection of Human Trafficking Victims 515.08MSS
AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law

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enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking. MSS Res 19, A-12

MSS Support of Business of Medicine Education for Medical Students 295.115
AMA-MSS will ask the AMA to encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. MSS Res 1, I-03; AMA Res 305, A-04 Adopted [D-295.958]

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 106
(November 2020)

Introduced by: Annie Huang; Avrohom Levy; Huasheng Wang, Midwestern University Arizona College of Osteopathic Medicine; Pareena Kaur, University of Arizona College of Medicine - Phoenix; Jeffrey Marsal, A.T. Still University School of Osteopathic Medicine in Arizona; Nikita Sood, Washington University School of Medicine in St Louis

Sponsored by: N/A

Subject: Providing Widespread Access to Feminine Hygiene/Menstrual Products

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Feminine hygiene products, also known as menstrual care products, are classified as tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation or other genital-tract secretions [1-2]; and

Whereas, Like toilets and toilet paper, menstrual hygiene products are necessary to effectively and sanitarily manage natural and unavoidable bodily functions [8]; and

Whereas, OSHA requires employers to provide all workers with sanitary and immediately-available toilet facilities (restrooms) according to sanitation standards 29 CFR 1910.141, 29 CFR 1926.51 and 29 CFR 1928.110[14]; and

Whereas, There are 166,650,550 women in the United States, of which 75 million are of childbearing age[6] , requiring the use of 7 billion tampons and 12 billion pads last year in 2019[7]; and

Whereas chronic abnormal uterine bleeding accounted for 57.7% of cases in a cross-sectional study and is one of the most common symptoms of gynecological conditions[13]; and

Whereas, Poor menstrual hygiene management is associated with reproductive tract infections[11] ; and

Whereas, The prevalence of dysmenorrhea varies between 16%-91% of reproductive age women[12]; and

Whereas, The FDA classifies feminine hygiene products as Class I and Class II medical devices [5]; and

Whereas, An estimated 86% of women have started their period in public without ready access to these necessary medical devices and 72% of these women left work early to obtain supplies [8]; and

Whereas, The 2010 U.S. Census estimates that employed part-time and full-time female workers spend an average 7.38 hours per day working at their place of employment--46.4% of

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average time spent awake--making it highly likely that working women will start their period or spend a significant portion of their period in the workplace [8, 9]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security Act established that money spent on menstrual care products are considered as if they were spent on medical care, and are eligible for reimbursement through Health Flexible Spending Arrangements and Health Reimbursement Arrangements, highlighting the role of feminine hygiene products as medical necessities [2]; and

Whereas, Our AMA agrees with this stance in existing policy (H-525.974) that "encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities"; and

Whereas, While our MSS, (160.032MSS), encourages publicly-funded institutions to provide menstrual products without cost, it does not have policy extending these guidelines to the workplace; therefore be it

RESOLVED, That our AMA encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons; and be it further

RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities", as follows:

> **Considering Feminine Hygiene Products as Medical Necessities, H-525.974**
> Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs. <u>(3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.</u>

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 107
(November 2020)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville

Sponsored by: Region 1

Subject: Updating AMA-MSS Policies Concerning International Medical Graduates and their Participation in the Physician Profession

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, An international medical graduate (IMG) is defined as someone, "who received their medical education from medical schools outside the United States (U.S.) and Canada"[1]; and

Whereas, As of 2017, 218,540 physicians, which represents approximately 24.5% of all U.S. physicians, are currently IMGs[2]; and

Whereas, The number of practicing IMG physicians continues to rise, seeing a 14.6% increase since 2010[3]; and

Whereas, The Association of American Medical Colleges (AAMC) predicts that there will be a shortage of between 46,900 and 121,900 physicians by 2032, which includes both primary care and specialties[4]; and

Whereas, Around 62% of IMG physicians practice primary care and IMGs are more likely in general to practice in areas with a physician shortage[3,5]; and

Whereas, The quality of the medical care, as measured by comparing patient mortality rates, was found to be equal or better for IMGs, and even more so for non-US citizen IMGs[6]; and

Whereas, In order to enter a graduate medical education (GME) program in the U.S., an IMG student must obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG), which then allows them to take USMLE Step 3[7]; and

Whereas, The ECFMG requires that international medical schools meet certain requirements, which means that IMGs with this certification have had their medical school credits verified and they have no need to be further individually vetted for this requirement[8]; and

Whereas, IMGs are required to complete a U.S. residency regardless of their level of training before coming to the country[9]; and

Whereas, IMGs who are attempting to train in a US residency often face difficulties, such as H-1B visa backlogs, time limitations, and restrictive immigration policies, in receiving a visa to begin their residency training, which further delays their ability to practice in the US[9,10,11,12]; and

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Whereas, IMGs often obtain J-1 exchange visa to complete residencies, which require them to require a waiver from the Conrad 30 program[11]; and

Whereas, The Conrad 30 program only provides states with 30 waivers per year regardless of their size or need[11]; and

Whereas, IMG residency trained physicians often face barriers in obtaining state licensure due to their medical training in countries outside of the US[5,9,11]; and

Whereas, State medical boards regulate the ability to receive a medical license, which means that requirements vary from state to state, and that states may implement additional requirements for IMGs[5,11]; and

Whereas, In states with more strict requirements for IMGs, there are less practicing physicians who are IMG's[5]; and

Whereas, It has been estimated that removing these barriers to receiving a state medical license could significantly decrease the physician shortage in many states with restrictive requirements[5]; and

Whereas, The AMA has its own IMG section, which has around 38,000 members and operates as an independent section within the AMA[13]; and

Whereas, The AMA has worked to increase knowledge and awareness surrounding IMG physicians and residents through programs such as IMG recognition week, which was first celebrated in 2019[14]; and

Whereas, The AMA recognizes that, "discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate" (AMA policy H-255.966); and

Whereas, AMA principles hold that, "medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor" (AMA policy H-255.988); and

Whereas, That same policy establishes the AMA in a "leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations" (AMA policy H-255.988); and

Whereas, The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character"(AMA policy H-255.983); therefore, be it

RESOLVED, That our AMA-MSS:
1) Recognizes the important contributions of international medical graduates to the United States health care system;
2) Opposes discrimination against medical students, residents, or physicians solely on the basis of national origin and/or the country in which they completed their medical education;
3) Supports equal and fair certification for international medical graduates as established by the Educational Commission for Foreign Medical Graduates (ECFMG);

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4) Supports that physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character; and
5) Supports legislation, policies, and rules that allow international medical graduates to obtain the appropriate visas and licenses to enter graduate medical education and practice medicine within the United States; and, be it further

RESOLVED, That our AMA-MSS amend 255.001MSS, The Status of Foreign Medical School Graduates in the United States, by addition and deletion as follows:

The Status of ~~Foreign~~ International Medical School Graduates in the United States, 255.001MSS

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

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Abolish Discrimination in Licensure of IMGs H-255.966
Medical Licensure of International Medical Graduates
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

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C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

Oppose Discrimination in Residency Selection Based on International Medical Graduate Status D-255.982

Our AMA:
1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.
2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.
3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms.

Visa Complications for IMGs in GME D-255.991

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary

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procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Unfair Discrimination Against International Medical Graduates H-255.978
It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPIN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and

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directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

Foreign Medical Graduates H-255.987

1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

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2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Study Expediting Entry of Qualified IMG Physicians to US Medical Practice D-255.978
Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.

Alternate Licensure Protocols for IMGs D-255.997

Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality; and (3) urges any insurance provider to accept appropriately amended medical records when underwriting decisions require medical record review.

Graduates of Non-United States Medical Schools H-255.983
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA)

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prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

Foreign Medical School Documentation 255.002MSS
AMA-MSS supports the concept that students from non- accredited medical schools be required to adequately document their clinical clerkships as a prerequisite for licensure and ECFMG certification

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

Licensure of International Medical Graduates 255.003MSS

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AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the development of separate licensing criteria, including exams, for any group.

Support Equal Standards for Foreign Medical Schools Seeking Title IV Funding 255.006MSS

AMA-MSS will ask that our AMA support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 108
(November 2020)

Introduced by: William T. Starbird, Aarthi Arab, Sally Nagia; Central Michigan University College of Medicine

Sponsored by: N/A

Subject: Use of Social Media for Product Promotion and Compensation

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Social media usage in the United States has increased with 81% of adults having a social media profile in 2017[1]; and

Whereas, Consumers cite physician posts and blogs as credible sources of health-related information emphasizing the inherent trust that exists between a patient and a physician, even if that physician is not the consumer's primary care provider[1]; and

Whereas, Social media "influencers" are online personalities with accounts on several social media platforms including, but not limited to, Instagram, Snapchat, TikTok, YouTube, and Facebook, that have influence over their large numbers of followers[2]; and

Whereas, Social media marketing, or "influencer marketing" has been cited to be the second most effective promotional strategy as compared to other forms of marketing; this allows many medical social media "influencers" to have an online presence reaching more consumers than a physician in a typical office setting or personal social media account[3]; and

Whereas, Physicians active on social media platforms may encounter conflicts of interests as companies, on average, offer Instagram "influencers" with 1,000-10,000 followers $114 for posting a video and an influencer with 1 million followers up to $7,000 per post for product promotion[4]; and

Whereas, The Physician Payments Sunshine Act (PPSA) legally requires medical product manufacturers to report payments or transfers of value to physicians in order to increase transparency and accountability in physicians and the receipt of such payments may diminish the trust the public has in the healthcare system and physicians[5]; and

Whereas, The American College of Physicians Ethics Manual states, "Physicians should fully disclose their financial interests in selling ethically acceptable products and inform patients about alternatives for purchasing the product"[6]; and

Whereas, Products promoted by physicians in the media may not be backed by research and have the potential to cause harm to the public through their inefficacy, therefore seeding mistrust in the medical profession[7,8]; and

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Whereas, The Federal Trade Commission has released guidelines for social media "influencers" on how and when to disclose that videos and posts are sponsored in order to "comply with laws against deceptive ads" and to increase transparency to their audience; and

Whereas, Healthcare workers have been disciplined for social media content and usage including but not limited to, the promotion of products for a company in which they were an authorized representative[9-11]; therefore be it

RESOLVED, That our AMA encourages medical students, residents, fellows, and physicians to separate their personal and professional online profiles so as to avoid undue influence when promoting the sale of non-health related products; and be it further

RESOLVED, That our AMA release a statement recommending that medical students, residents, fellows, and physicians adhere to the FTC guidelines for disclosing financial, employment, personal, and family relationships with a company on social media posts; and be it further

RESOLVED, That our AMA develop ethical guidelines for medical students, residents, fellows, and physicians around endorsing non-health related products through social and mainstream media for personal or financial gain.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

D-105.995 Protecting Social Media Users by Updating FDA Guidelines
Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.
Res. 209, I-15

3.1.5 Professionalism in Relationships with Media
Ensuring that the public is informed promptly and accurately about medical issues is a valuable objective. However, media requests for information about patients can pose concerns about patient privacy and confidentiality, among other issues.

Physicians who speak on health-related matters on behalf of organizations should be aware of to institutional guidelines for communicating with media, where they exist. To safeguard patient interests when working with representative of the media, all physicians should:

(a) Obtain consent from the patient or the patient's authorized representative before releasing information.

(b) Release only information specifically authorized by the patient or patient's representative or that is part of the public record.

(c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician.

(d) Refer any questions regarding criminal activities or other police matters to the proper authorities

AMA Principles of Medical Ethics: IV

Identification of Physicians by the Media H-485.991
It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary he or she be specifically identified with the appropriate initials "MD" or

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"DO" after his or her name; and that others be identified with the appropriate degrees after their names.
Res. 601, I-01; Reaffirmation I-09; Reaffirmed: BOT Rep. 09, A-19

Ethical Physician Conduct in the Media D-140.957
1. Our AMA will study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform.

2. Our AMA will release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.
Res. 16, A-15; Modified: CEJA Rep. 02, I-17

8.11 Health Promotion and Preventive Care
Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.

(b) Educate patients about relevant modifiable risk factors.

(c) Recommend and encourage patients to have appropriate vaccinations and screenings.

(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.

(e) Collaborate with the patient to develop recommendations that are most likely to be effective.

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(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.

(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

(h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.

(j) Advocate for healthier schools, workplaces and communities.

(k) Create or promote healthier work and training environments for physicians.

(l) Advocate for community resources designed to promote health and provide access to preventive services.

(m) Support research to improve the evidence for disease prevention and health promotion.

AMA Principles of Medical Ethics: V,VII

Code of Medical Ethics Opinion 9.6.4
The sale of health-related products by physicians can offer convenience for patients, but can also pose ethical challenges. “Health-related products” are any products other than prescription items that, according to the manufacturer or distributor, benefit health. “Selling” refers to dispensing items from the physician’s office or website in exchange for money or endorsing a product that the patient may order or purchase elsewhere that results in remuneration for the physician.

Physician sale of health-related products raises ethical concerns about financial conflict of interest, risks placing undue pressure on the patient, threatens to erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the profession of medicine.

Physicians who choose to sell health-related products from their offices or through their office website or other online venues have ethical obligations to:

(a) Offer only products whose claims of benefit are based on peer-reviewed literature or other sources of scientific review of efficacy that are unbiased, sound, systematic, and reliable. Physicians should not offer products whose claims to benefit lack scientific validity.

(b) Address conflict of interest and possible exploitation of patients by:

1. Fully disclosing the nature of their financial interest in the sale of the product(s), either in person or through written notification, and informing patients of the availability of the product or other equivalent products elsewhere.
2. Limiting sales to products that serve immediate and pressing needs of their patients (e.g., to avoid requiring a patient on crutches to travel to a local pharmacy to purchase the product). Distributing products free of charge or at cost makes products readily

available and helps to eliminate the elements of personal gain and financial conflict of interest that may interfere, or appear to interfere with the physician's independent medical judgment.

(c) Provide information about the risks, benefits, and limits of scientific knowledge regarding the products in language that is understandable to patients.

(d) Avoid exclusive distributorship arrangements that make the products available only through physician offices. Physicians should encourage manufacturers to make products widely accessible to patients.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 109
(November 2020)

Introduced by: Haidn Foster, University of Cincinnati College of Medicine; Leanna Knight, Davy Ran, University of Rochester School of Medicine and Dentistry; Christopher Wong, Baylor College of Medicine

Sponsored by: N/A

Subject: Transgender and Intersex Care Training for School Health Professionals

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Gender dysphoria is defined as "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth"[1]; and

Whereas, 700,000 adults in the United States identify as transgender[2]; and

Whereas, Individuals with disorders/differences of sex development (DSD)—also known as intersex—have "congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical," as defined by the 2006 Consensus Statement[3]; and

Whereas, Individuals with DSD comprise approximately 1% of the U.S. population[3]; and

Whereas, The American Academy of Pediatrics recognizes school nurses as promoting optimal biopsychosocial health in school-aged children in the school setting[4]; and

Whereas, The National Association of School Nurses believes that, "School nurses have an ethical responsibility to provide care to all students, families, school staff and community equally regardless of sexual orientation, gender identity or gender expression; to maintain confidentiality and to respect the individual's right to be treated with dignity"[5]; and

Whereas, The Surgeon General identified LGBTQ youth to be at heightened risk for suicide compared to their cisgender, heterosexual peers, a major risk factor for which was not feeling safe at school[6,7]; and

Whereas, Transgender youth report elevated risk for suicide, depression, and substance use[8,9]; and

Whereas, Individuals with DSD are at increased risk of cancer, infertility, psychosocial distress, and other adverse health outcomes[3]; and

Whereas, National school climate surveys have found that LGBTQ youth are often exposed to minority stress—a form of chronically high stress faced by members of stigmatized minority groups—in school settings[10]; and

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Whereas, LGBTQ youth with greater school connectedness and safety report lower suicidal ideation and attempts[11]; and

Whereas, Comfort with a trusted health care provider correlated positively with mental and physical health among transgender youth[12]; and

Whereas, The Centers for Disease Control and Prevention (CDC) endorse strategies for schools to meet the needs of LGBTQ youth, including encouraging school staff members to attend professional development on safe and supportive school environments for all students—regardless of sexual orientation, gender identity, or gender expression[13]; and

Whereas, An average of 15.3% of schools follow all five practices recommended by the CDC[14]; and

Whereas, In 2017, 45.5% of school-based health systems conducted no medical provider trainings on LGBTQ care and 54.5% conducted no general staff trainings on providing care for LGBTQ youth[15]; therefore be it

RESOLVED, That our AMA recommends school-based health professionals serving children and adolescents receive training in the physical and mental development of youth with gender dysphoria and/or differences in sex development, and that this training be periodically assessed and renewed.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Providing Medical Services through School-Based Health Programs H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient

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services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

CSA Rep. D, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: Res. 412, A-05 Reaffirmed in lieu of Res. 908, I-12

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

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

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

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

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CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 110
(November 2020)

Introduced by: Michael Moentmann, Michael Franklin, Sachin Ketkar, Ashton Lewandowski, Peter Dimitrion, Wayne State University School of Medicine

Sponsored by: N/A

Subject: Support distribution of free hearing protection in relevant public venues

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The Occupational Safety and Health Administration (OSHA) acknowledges that continued exposure to sound levels greater than 85 dBA can result in permanent hearing loss, and therefore enforces stringent guidelines related to occupational sound exposure[1,2]; and

Whereas, Concerts, sporting events, and other loud entertainment venues, including nightclubs and bars, can have average sound levels of over 85 dBA for many hours, and can reach noise levels between 105-110 dBA, which can rapidly cause short term and long term hearing loss[2,3,4,5]; and

Whereas, Usage of protective earplugs by rock concert attendees increased from 1.3% to 8.2% when they were provided for free and resulted in a reduction in short term hearing loss, from 42% to 8%[6,7,8]; and

Whereas, Employees in workplaces where sound exposure exceeds 85 dBA are entitled by OSHA to receive free hearing protection from their employer[1]; and

Whereas, Some U.S. cities have required bars and live music venues to make earplugs available, and the low cost of providing hearing protection to the public at live music events could easily be added to ticket prices[6,9,10]; and

Whereas, Our AMA has supported free public distribution of low-cost consumer health products in public spaces where there is a risk of environmental exposures, as in the case of sunscreen in public spaces (H-440.839); therefore be it

RESOLVED, That our AMA supports the availability of free hearing protection, such as foam earplugs, in public spaces where noise levels exceed 85 dBA, such as bars and live music venues.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Noise Induced Hearing Loss In Children And Adolescents H-440.897
(1) Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents.
(2) Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour.
(3) Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL.
(4) Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.
(Res. 407, I-00) (Reaffirmed: CSAPH Rep. 6, A-08) (Appended: Res. 411, A-16)

Reporting Potential for Hearing Loss Due to Personal Listening Devices H-440.957

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It is the policy of the AMA that: (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of personal listening devices and the occurrence of short-term and long-term noise-induced hearing loss; and (3) portable listening devices limit the maximum sound amplitude to safe levels.
(BOT Rep. A, A-90) (Reaffirmed: Sub. Res. 506, I-93) (Amended: CSA Rep. 8, A-03) (Reaffirmed: CSAPH Rep. 6, A-08) (Modified: Res. 518, A-18) (Modified: CSAPH Rep. 01, A-18)

Noise Pollution H-440.864
Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure.
(Sub. Res. 417, A-08) (Reaffirmation A-16)

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
(1) Our AMA encourages physicians to counsel their patients on sun-protective behavior.
TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

(2) Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of sun protection as a public health measure.

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(3) Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.
(CCB/CLRPD Rep. 3, A-14) (Appended: Res. 403, A-14) (Appended: Res. 404, A-19) (Appended: Res. 905, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 111
(November 2020)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville; Victoria Gordon, Kansas City University of Medicine and Biosciences

Sponsored by: N/A

Subject: Amending H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses to Increase Utilization and Expand Use of Alternative Funding for Collaborative Care

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, In 2017, an estimated 46.6 million adults in the United States live with mental illness, which is 18.9% of all U.S. adults[1]; and

Whereas, In 2017, 43% (19.8 million) of all adults with mental illness received mental health services in the past year[1]; and

Whereas, A previous analysis of claims data showed that Medicare and Medicaid patients who have comorbid physical and mental health problems have health care costs for the non-mental health illnesses that are 2-3 times higher than other beneficiaries without mental health problems[2]; and

Whereas, Primary care physicians are the main providers of mental health service for patients with common mental illnesses such as depression and anxiety[3]; and

Whereas, The collaborative care model is an evidence-based approach to integrate physical and behavioral health services in primary care settings[3]; and

Whereas, Collaborative care involves care coordination and care management, regular monitoring and treatment to target using validated clinical rating scales, and regular, systematic psychiatric caseload reviews[3]; and

Whereas, The collaborative care team includes the primary care provider, who serves as the treating physician, the care manager, who provides therapy to the patients, and the psychiatric consultant, who manages all of the patients within the collaborative care model by making suggestions about treatment plans[3]; and

Whereas, Collaborative care involves an initial assessment by the primary care physician, who will then consult with the care manager for involvement within this model. The PCP and the care manager will then provide treatment to the patient, which can involve both medicine and therapy. The psychiatric consultant will regularly review the caseload and offer treatment recommendations[3]; and

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Whereas, A Cochrane review that included 79 randomized control trials and 24,308 participants demonstrated significantly greater improvement in both depression and anxiety in patients treated in a collaborative care model as compared to those treated in a usual care model[4]; and

Whereas, One study done in patients aged 65 years or older found significant improvements over a year in both mental and physical health outcomes of patients in collaborative care compared to those in standard care, with collaborative care patients scoring 1.31 and 1.33 points lower on PHQ-9s at 4 and 12 months, respectively[5]; and

Whereas, A study of 8 rural clinics using collaborative care for low-income patients with depression found that patients' average PHQ-9 score significantly decreased from 16.1 to 10.9 over 18 months[6]; and

Whereas, A study done in an adolescent population that utilized both health plan cost and use data with clinical depression scale scores found that that the collaborative care model was more effective in reducing depressive symptoms and only marginally more expensive than usual care, although it resulted in both a net cost savings and a net increase in quality adjusted life years[7]; and

Whereas, A 4-year cost analysis of collaborative care found that initial investment of $522 resulted in net savings of $3,363 after 4 years[3,8,]; and

Whereas, Using data from cost analyses, some researchers estimated that the use of collaborative care for the one in five Medicaid members with diagnosed depression could save Medicaid approximately $15 billion per year[3,9,10]; and

Whereas, Fee-for-service reimbursement models might serve as barriers to the implementation of the collaborative care model, but newer payment models (such a capitated payments or pay-for-performance payments) offer opportunities to increase its use in clinical practice[3]; and

Whereas, Appropriate CPT codes already exist for physicians and practices to utilize when billing for psychiatric care through the collaborative care model, although these services are not reimbursed by Medicaid in every state[11,12]; and

Whereas, Section 2703 of the Affordable Care Act, better known as the Medicaid Health Home State Plan Option, can be used as a vehicle to incorporate the principles of collaborative care into the care management of complex Medicaid populations via an amendment to Medicaid state plan services[3]; and

Whereas, A Medicaid Health Home is defined as, "a mechanism to coordinate the primary, acute, behavioral, and long-term and social service needs of targeted beneficiaries"[3]; and

Whereas, Under the Home Health model, "states can link Medicaid beneficiaries who have at least two chronic conditions, have one chronic condition and are at risk for another, or have a serious mental illness to a health home to coordinate that person's health care"[3]; and

Whereas, The American Psychiatric Association (APA) has developed resources and advocacy tools to assist in passing legislation within states that do not currently offer Medicaid reimbursement for psychiatric care through a collaborative care model[11, 12]; and

Whereas, Section 1115 of the Social Security Act allows states to apply for additional funding for projects that "promote the objectives of Medicaid and Children's Health Insurance Program (CHIP) programs"[13]; and

Whereas, Utilizing these waivers can allow states to waive certain provisions of their state Medicaid laws, which would allow them to implement Medicaid programs that might not be currently covered under their current Medicaid reimbursements[13]; and

Whereas, In addition to 1115 waivers, there are various mechanisms that exist within Medicaid, the Affordable Care Act, and other federal laws that would allow states to obtain increased funding levels to specifically increase their collaborative care programs[11,12]; and

Whereas, Previous AMA policy has supported the concept of collaborative care as a way to address mental health within primary care (AMA Policy H-345.984); therefore, be it

RESOLVED, That our AMA amend policy H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses, by addition and deletion as follows:

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

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; ~~and~~ (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings; and (d) will

advocate for increased utilization and expansion of alternative funding sources for collaborative care models, including advocating for the use and expansion of section 1115 waivers in states that currently utilize these waivers.

4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.
Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.

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(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation A-15

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16

Integrating Physical and Behavioral Health Care H-385.915

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Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.
CMS Rep. 6, A-15

Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services H-345.980
Our AMA advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and substance use disorder services to our citizens.
Res. 205, A-06; Modified: CMS Rep. 01, A-16

CPT Codes for Medical Management of Mental Illness for Outpatients H-345.987
Our AMA (1) continues to support the concept that medical management of mental illness is comparable to the medical management of any other illness; and (2) will communicate the appropriate ways to report medical management and case supervision of mental illness, both on an inpatient and outpatient basis, to physicians and third party payers.
BOT Rep. C, I-91; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Access to Mental Health Services D-345.997
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.
CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Modified: Res. 503, A-17

Co-Location of Behavioral Health Care and Primary Care 345.014MSS
AMA-MSS supports the co- location of behavioral health services within primary care clinics and other locations where primary care services are provided. (MSS Res 11, A-17)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 112
(November 2020)

Introduced by: Jenna Gage, Kaci French, University of Texas Medical Branch

Sponsored by: Region 3

Subject: Guaranteed Time Off on National Election Days at Medical Schools

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Voting is a constitutional right and is considered the most basic expression of civic participation[1]; and

Whereas, Voting has been shown to have a relationship with other civic behaviors, even suggesting a causative relationship between voting and civic engagement[2]; and

Whereas, Civic engagement from medical professionals has also been identified to improve medicine's relationship with society[3,4,5]; and

Whereas, Medical students are eager to participate in the political process and view addressing healthcare policy as a professional responsibility[6]; and

Whereas, Medical student voter participation has the potential to be highly influential on the future of healthcare in our society[6] and it is important to allot the time needed for engagement in important historic events; and

Whereas, Voter turnout is dependent on ability and ease of voting[7,8] and conflicting work or school schedule is consistently one of the top reasons registered nonvoters report for not voting[9]; and

Whereas, Many medical students feel that their schools do not adequately allocate time for students to vote and participate in the political process[10]; and

Whereas, Whereas, AMA policy grants time off for resident involvement in organized medicine but has failed to address barriers that prevent medical students from voting (H-310.911); and

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

RESOLVED, That our AMA will work with appropriate stakeholders to guarantee time off on National Election Days at medical schools.

Fiscal Note: TBD

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Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

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

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

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

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

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician

relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

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

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

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(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
4. Hospital Medical Staff Relations
a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.
5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the

clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 113
(November 2020)

Introduced by: Drew Sanderson, UT Health San Antonio-Long School of Medicine

Sponsored by: Region 2, Region 3

Subject: Implications of the Dismissal of Vaccine-Noncompliant Patients

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, This resolution defines vaccine-noncompliance as any patient who does not completely adhere to standard CDC vaccination schedules for any non-medical reason, deliberately or not, including but not limited to: vaccine hesitancy, alternative vaccine schedules, non-medical exemption, total or partial vaccine refusal, conscientious objection, missed appointments, lack of insurance coverage, and/or cost concerns[1]; and

Whereas, On April 25th, 2019 the CDC reported the highest number of measles cases in the country since measles was declared eliminated in 2000[2]; and

Whereas, A 2019 survey revealed that 45% of the more than 2,000 U.S. adults surveyed said they doubt vaccine safety[3]; and

Whereas, Conscientious objection or refusal of medical services is an exercise of patient autonomy in medical decision-making, and children who often do not have full capacity to make autonomous decisions are nonetheless victims of any resulting consequences[4]; and

Whereas, The CDC states that both people who are immunocompromised and people who are not fully vaccinated have increased vulnerability to infection with vaccine-preventable diseases[5,6]; and

Whereas, An inherent trade-off exists when physician practices adopt policies mandating dismissal of vaccine-noncompliant patients in an attempt to better protect vulnerable immunocompromised patients at the expense of decreased protection for vulnerable vaccine-noncompliant patients due to the removal of their medical home[7,8]; and

Whereas, This trade-off may have particularly burdensome consequences for patients in areas with a shortage of physician practices, such as rural America[9,10]; and

Whereas, Widespread adoption of policies endorsing dismissal of vaccine-noncompliant patients may result in a prevalent physician-imposed burden of healthcare inaccessibility for those patients[8,10,11]; and

Whereas, Such policies may increase the risk of disease outbreak by clustering unvaccinated patients into fewer practices that tolerate non-vaccination or alternative vaccine schedules[8]; and

Whereas, Physicians' dismissal of vaccine-noncompliant families runs against recommendations from the American Academy of Pediatrics (AAP) Committee on Bioethics that

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state “in general, pediatricians should endeavor not to discharge patients from their practices solely because a parent refuses to immunize a child”[12]; and

Whereas, Motivational interviewing (MI), a form of intervention that uses a patient-centered approach to "enhance the patients’ internal motivation to change by exploring and solving their own ambivalence,"[13] has been shown to increase vaccine compliance[13-17]; and

Whereas, The Canadian Pediatric Society supports motivational interviewing in vaccine counseling and recommends that medical providers “understand the key role that sound vaccine advice from a health care provider can play in parental decision-making, and do not dismiss vaccine refusers from your practice”[14]; and

Whereas, One study that used motivational interviewing with parents during their post-partum stay showed an “increase of 15% in the parents’ intention to vaccinate their infant at 2 months of age (72–87%, $p < 0.001$), a 7% increase in vaccine coverage at 7 months (69–76%, $p < 0.001$), and a 9% higher likelihood that infants whose parents received the intervention in the maternity ward had a complete 0–2 year vaccine coverage (RR = 1.09 [1.05–1.13])”[13]; and

Whereas, Another study using motivational interviewing (MI) for vaccine counseling in a community pharmacy found that “patient readiness to receive immunizations improved from the beginning to the end of the MI encounter and was statistically significant for hepatitis B (P = 0.001) and pneumococcal (P = 0.033) vaccines,” and “pharmacists agreed MI was an effective tool to discuss immunizations”[15]; and

Whereas, Another study on HPV vaccine hesitancy found that incorporating motivational interviewing “techniques into clinical visits did not increase visit times, did help somewhat to improve provider self-efficacy for discussing the vaccine with hesitant parents, and was perceived by providers as effective at reducing vaccine-hesitant parents’ resistance to HPV vaccines for their children”[16]; and

Whereas, A 2020 review article in Current Opinion in Pediatrics found that “provider communication strategies may improve immunization rates including...motivational interviewing”[17]; and

Whereas, All US children should receive recommended vaccines against diseases to protect the public health (AMA National Immunization Program H-440.992); and

Whereas, Respect for patients’ autonomy is a cornerstone of medical ethics (AMA Code of Medical Ethics, 11.2.4: Transparency in Healthcare); and

Whereas, The AMA has remained heavily involved in advocating for physician autonomy (AMA Code of Medical Ethics, Principles of Medical Ethics: VI) in the provision of patient care and in advocating for policies that increase vaccination rates (AMA Education and Public Awareness on Vaccine Safety and Efficacy H-440830), including counseling (AMA Financing of Adult Vaccines: Recommendations for Action H-440.860), but it has yet to assess the medical and public health implications of physicians using their autonomy to implement policies requiring dismissal of vaccine-noncompliant patients; therefore be it

RESOLVED, That to better assess the net medical and public health implications of widespread dismissal of vaccine-noncompliant patients from physician practices, our American Medical Association (AMA) support the comparative study of the impact of physician practices engaging

in motivational interviewing versus the impact of physician practices dismissing vaccine-noncompliant patients, including the following suggested measures:

1. change in individual vaccine compliance status
2. rates of vaccination within communities
3. rates of infection with vaccine-preventable diseases in the community and in participating physician practices, especially among the immunocompromised
4. number of vaccine-noncompliant patients with a reliable primary care provider (medical home.

Fiscal Note: TBD

Date Received: 08/01/2020

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Relevant AMA and AMA-MSS Policy

Code of Medical Ethics Opinion 1.1.7

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the

physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

Transparency in Health Care 11.2.4

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities may have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians share in this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient's care.

(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.

(c) Encourage patients to be aware of the provisions of their health plan.

Collectively, physicians should advocate that health plans with which they contract disclose to patient-members:

(d) Plan provisions that limit care, such as formularies or constraints on referrals.

(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.

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(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians' treatment recommendations.

AMA Principles of Medical Ethics: I,II,III,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 2016

Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress D-390.974

Our AMA will:

(1) continue working to identify politically viable modifications to the statutory language on private contracting that will make opting out a more reasonable choice for practicing physicians; and

(2) educate physicians on the different options for participating in the Medicare program and provide our members with the tools and information necessary to analyze the impact on their patients, their practice, and the US Congress, of their choice of the three modes of relating to the Medicare program by:
(a) opting out of Medicare; or
(b) caring for Medicare patients in a fee-for-service relationship, making the decision to "accept assignment" on the basis of mutual needs of the patient and the physician; or
(c) continuing as a "participating physician" in the Medicare program understanding that the physician is subject to the continued anticipated reductions in direct reimbursement and the ultimate inability to directly negotiate any fees on behalf of their practice. This may give Congress the wrong impression that there is no problem with continued fee reductions.

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link

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between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.

2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i)

Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management. CSAPH Rep. 4, I-08 Reaffirmation I-10 Reaffirmation: I-12 Reaffirmation I-14

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).

2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

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4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Distribution and Administration of Vaccines H-440.877

1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.

2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.

3. Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines;

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(c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.

4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.

5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.

6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.

7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.

8. Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

Update on Immunizations and Vaccine Purchases H-440.928

Our AMA: (1) encourages state and local health departments to identify local barriers to immunization and collaborate with state and local medical societies to devise plans to eliminate the barriers.

(2) encourages the Administration and Congress to consider immunization initiatives within the broader context of health system reform and payment for preventive care services, and not only as a separate issue.

(3) will release a public statement and actively advocate for increased federal funding for vaccines, including activities funded through Section 317 of the Public Health Service Act, which supports purchasing vaccines and implementing the national vaccine strategy, and includes monies for education of the American public about the importance of immunization, education and training for health professionals, and for support to state and local governments to remove barriers to effective immunization.

(4) encourages states and other public health entities to make greater use of the option they have through their grantee to use their own appropriated funds to purchase vaccines at the Centers for Disease Control and Prevention contract price and encourages vaccine manufacturers to make the contract vaccine price widely available to such purchasing agents. This would further increase availability of vaccines at the best available price.

(5) encourages private physicians and groups such as HMOs to work together with vaccine manufacturers to secure a negotiated bulk purchase price for vaccines by guaranteeing a larger volume of purchase and lower administrative costs.

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(6) encourages health insurance companies to cover the cost of vaccine purchase and administration for all childhood immunizations since immunization of young children is highly cost effective.

(7) encourages all states to alter their Medicaid program so that childhood vaccines can be purchased at the federal contract price and private physicians can be reimbursed for immunization services and cost of vaccine purchase.

National Immunization Program H-440.992

Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.

(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.

(3) There should be no financial barrier to immunization of children.

(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.

(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.

(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.

(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.

(8) An efficient immunization record-keeping system should be instituted. Res. 44, A-77 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: Res. 501, A-09 Reaffirmation I-10

AMA CODE OF MEDICAL ETHICS

AMA PRINCIPLES OF MEDICAL ETHICS*

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

Principles of medical ethics

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I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

∗ Revised June 2001.

A Comprehensive Education Strategy to Improve Vaccination Rates 440.051MSS

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 114
(November 2020)

Introduced by: Michael B. Bagg, Ikram Rostane; McGovern Medical School

Sponsored by: N/A

Subject: Support for administration of STEP examinations by home institutions

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, There is wide variety in quality of third-party testing sites for STEP 1, STEP 2CK, COMLEX level 1 and COMLEX level 2CE exams; and

Whereas, Prior to COVID-19, students routinely have to schedule months in advance to guarantee a STEP 1, STEP 2CK, COMLEX level 1 and COMLEX level 2CE exams; and

Whereas, Students routinely take several National Board of Medical Examiners (NBME) subject examinations at their home institutions without major issues regarding test security[1, 2]; and

Whereas, Due to the COVID-19 Pandemic, close to 17,000 medical students and residents were unable to take their scheduled STEP 1, STEP 2CK, COMLEX level 1 and COMLEX level 2CE exams starting from March 2020 to now[3]; and

Whereas, Due to the COVID-19 Pandemic, students have been unable to reliably communicate with the sole third-party testing administrator because of the lack of a call center[4]; and

Whereas, Due to the COVID-19 Pandemic, there have been numerous reports of examinations being cancelled by third-party administrators without properly informing test-takers as late as less than 24 hours before the exam[5]; and

Whereas, There have been numerous reports of students crossing state lines during a pandemic attempting to take a board examination[5]; and

Whereas, Due to the COVID-19 Pandemic, The United States Medical Licensing Examination (USMLE) has implemented and administered on-site medical school testing at 38 schools across the nation in June 2020[6]; and

Whereas, Due to the success and increased availability of spots the on-site medical school testing created, USMLE expanded to 63 schools across the U.S. in August 2020[7]; and

Whereas, In one of these schools, New York Medical College, administrators have expressed that administering the exam on their campus eliminated much of the stress and fear many students had about cancellations and gave them a more comfortable setting to test in[3]; and

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Whereas, The pandemic has exacerbated pre-existing concerns regarding the ability to provide consistent, reliable, and convenient administration of board examinations by third-party testing centers; therefore be it

RESOLVED, That our AMA-MSS support the continued exploration of a permanent shift in the administration of written STEP and COMLEX examinations away from third-party testing sites and toward primary administration of home institutions with the supplementation of third party testing sites to accommodate test takers incapable of testing at home institutions.

Fiscal Note: TBD

Date Received: 09/20/2020

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7. *USMLE Completes Third Testing Event With Medical School Support | CORONAVIRUS RESOURCE CENTER*. *Covid.Usmle.Org*, 2020, from https://covid.usmle.org/announcements/usmle-completes-third-testing-event-medical-school-support.

RELEVANT AMA AND AMA-MSS POLICY

Medical Licensure H-275.978
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

Independent Regulation of Physician Licensing Exams D-295.939
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination

system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

Clinical Skills Assessment During Medical School D-295.988
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Demonstration of Clinical Competence H-275.956
It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians.

Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools 275.011MSS
The AMA-MSS will (1) ask our AMA, working with the state medical societies, to advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance

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Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 115
(November 2020)

Introduced by: Samantha Pavlock, Florida State University College of Medicine; Rebecca Anderson, University of Nebraska Medical Center; Morgan Haynes, University of New Mexico School of Medicine; Krithika Sundaram, Meghana Chanamolu; Northeast Ohio Medical University; Roshini Srinivasan, Duke University School of Medicine; Nicolette Codispoti, Loyola University Chicago Stritch School of Medicine; Shreya Kondle, University of Texas Southwestern Medical School.

Sponsored by: Region 2, Region 4, Region 5

Subject: Support for Endometriosis

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Endometriosis is estimated to affect 176 million people worldwide, and is a cause of significant economic burden, costing $70 billion dollars annually in the United States alone[1]; and

Whereas, Presently, there is no known cause or cure for endometriosis, which can manifest as chronic pelvic pain, painful menstrual cycles, abnormally heavy and prolonged bleeding, and pain with sexual intercourses[2,3]; and

Whereas, Endometriosis is a leading cause of infertility, with 30% of infertile women and 50% of moderate-to-severe dysmenorrhea patients diagnosed with endometriosis after surgical investigation[4,5], and

Whereas, Providers are frequently unfamiliar with the far-reaching scope of endometriosis and cite many challenges caring for patients with the disease[6]; and

Whereas, The average patient with endometriosis will spend 10 years seeing 5 doctors before being diagnosed, resulting in misdiagnosis or delayed diagnosis with unnecessary and inappropriate treatment measures leading to additional costs to both patients and healthcare systems[7,8]; and

Whereas, Endometriosis diagnosis and management amount to $152.21 million in 5-year healthcare costs alone, including but not limited to hysterectomy costs of $4,915 per case, hospitalizations without surgical intervention of $2,101 per case, and average hospitalization costs of $3,143 per case[7]; and

Whereas, Patients with moderate to severe endometriosis who are unable to conceive are recommended in vitro fertilization (IVF), with out-of-pocket costs in the United States of $27,360 per treatment and the total cost of successful outcomes averaging $132,174[9,10]; and

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Whereas, Women with endometriosis experience diminished quality of life, increased incidence of depression, adverse effects on intimate relationships and social life, limitations in daily activities, loss of productivity and associated income, and increased risk of chronic disease[11,12]; and

Whereas, On the list of diseases receiving funding from the National Institutes of Health, endometriosis is one of the least funded, ranked 256 out of 292, which is greatly limiting our understanding of the disease and slowing much-needed innovation in diagnostic and treatment options[13,14]; and

Whereas, The AMA presently supports the World Health Organization's designation of infertility as a disease state with complex and multifaceted etiology requiring interventions for the advancement of its treatment and prevention (H-420.952); and

Whereas, The AMA and AMA-MSS support the formal establishment of evidence-based screening recommendations and the clinical implementation of new treatments for other chronic conditions similar to endometriosis where expedient detection may result in earlier, more effective intervention such as in sickle cell disease (H-350.973), celiac disease (H-425.971 and 440.043MSS), hepatitis C (H-440.845 and 440.040MSS), and tuberculosis (440.008MSS); and

Whereas, The AMA supports biomedical research, advocacy, and awareness of several diseases which have significant healthcare, economic, and social burdens similar to endometriosis, including but not limited to systemic lupus erythematosus (H-460.912), sickle cell disease (H-350.973), human papilloma virus (H-440.872), and hepatitis C (H-440.845); and

Whereas, The AMA and AMA-MSS encourages educational efforts tailored to healthcare providers and the general public regarding awareness and management of chronic diseases with a similar prevalence to endometriosis (H-350.973, H-440.845, H-440.872, 440.008MSS, 440.040MSS); and therefore be it

RESOLVED, That our AMA recognize endometriosis as a chronic illness and a leading cause of infertility in the United States; and be it further

RESOLVED, That our AMA encourage appropriate screening programs to detect endometriosis including early-detection methods to reduce the current burden on our healthcare system and prevalence of infertility among endometriosis patients; and be it further

RESOLVED, That our AMA advocate for increased federal funding from the National Institutes of Health for biomedical research that works towards finding the etiology and optimal management for endometriosis; and be it further.

RESOLVED, That our AMA advocate for physician and patient education and awareness of endometriosis including developing provider training on diagnosis and management.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention (Res. 518, A-17).

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Systemic Lupus Erythematosus Research H-460.910
Our AMA supports funding for biomedical research and educational programs that work toward finding the cause and a cure for lupus. (Res. 510, A-08; Modified: CSAPH Rep. 01, A-18).

Sickle Cell Disease H-350.973
(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease. (CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Modified: BOT Rep. 12, A-11Appended: Res. 906, I-19)

Celiac Disease Screening H-425.971
Our AMA: (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders (Res. 419, A-13).

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment (Res. 906, I-12 Modified: Res. 511, A-15 Modified: Res. 410, A-17).

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b)

encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA: (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. (Res. 503, A-07; Appended: Res. 6, A-12.)

Health Promotion and Disease Prevention Education 295.022MSS
AMA-MSS supports improvements in health promotion/disease prevention curricula in medical schools, residency programs, and CME programs. (MSS Sub Res 31, A-90) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16).

Infertility and Infertility Insurance Coverage 420.010MSS
AMA-MSS: (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons. (MSS Res 24-I-17).

Tuberculosis Resurgence and Physician Awareness 440.008MSS
AMA-MSS will ask the AMA to: (1) work with the Centers for Disease Control (CDC) to educate physicians and the public on the recent resurgence and unusual presentations of tuberculosis; and (2) work with the CDC to promote improved methods of screening, treatment, and prevention of further transmission of tuberculosis. (AMA Res 404, A-92) (BOT Amended Rep OO, A-92, Adopted in Lieu of Res 404 and 407 [H-440.938]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS Res 27, A-14).

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

Promoting Celiac Disease Screening Usage and Standards 440.043MSS
AMA-MSS (1) recognizes undiagnosed celiac disease as a public health problem; and
(2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (MSS Res 14, A-13).

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 116
(November 2020)

Introduced by: Jan Alexander Niec, Rahul Ramaswamy, Daniel Enrique Pereira, Megan McLeod, Jennifer Connell, Alexander Lupi, Vanderbilt University School of Medicine

Sponsored by: N/A

Subject: Standardizing Counseling for Pediatric Victims of Gun Violence

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to develop policies that would guarantee access to needed family support services, psychosocial services and medical services (H-60.981); and

Whereas, Gun violence is the second-leading cause of death among children overall and the first-leading cause of death among black children ages 0-17[1]; and

Whereas, Nearly 1300 children die and 5790 are treated for gunshot wounds each year[2]; and

Whereas, Three-million American children are directly exposed to gun violence each year, resulting in lasting trauma, psychological distress, and decreased potential[3]; and

Whereas, Only 6% of families with firearms store firearms safely[4]; and

Whereas, Counseling by health care providers results in safe firearm storage practices in the home[4]; and

Whereas, Our AMA supports the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes (H-145.975); and

Whereas, Counseling interventions can take place in the emergency department, outpatient, or inpatient settings[4]; and

Whereas, Counseling interventions in response to pediatric gunshot injury are variable[4];

Whereas, Interventions including the provision of gun safety devices increased gun safety in the home compared to those that relied solely on verbal and written counseling[4]; therefore be it

RESOLVED, That our AMA collaborate with relevant stakeholders such as American Academy of Pediatrics to encourage the development of evidence-based standard counseling protocols for children who are shot or exposed to gun violence, including in the emergency department settings.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Adolescent Health H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance

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use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 117
(November 2020)

Introduced by: Siri Tummala, TCU and UNTHSC School of Medicine; Abhishek Dharan, Kristopher Van Huss, Andrew Williams, Foster School of Medicine TTUHSC El Paso

Sponsored by: N/A

Subject: Impact of Matching Social Interests on Undergraduate Medical Education on Clinical Evaluation

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Matching social interests are defined as shared preferences between evaluators and undergraduate medical students representative of one's experiences including one's gender, race, cultural background, political inclinations, and personality[1]; and

Whereas, Undergraduate medical students surveyed across institutions at the end of the core clerkship year raised concerns about possible biases within clerkship evaluations[2]; and

Whereas, The correlation between external nonacademic conditions and academic performance guidelines is not clear[3]; and

Whereas, Evaluations of core clerkship rotations included descriptions of students' individual traits as opposed to their academic performance[4]; and

Whereas, Humans have a penchant for interacting with individuals who share similar preferences as them[1]; and

Whereas, Female evaluators evaluated female undergraduate medical students of the same gender better than male students[5]; and

Whereas, White undergraduate medical students scored higher on final clerkship evaluations than non-white students[3]; and

Whereas, Individuals rated people with similar musical tastes as them higher than people with different music tastes[1]; and

Whereas, A study conducted on 163 participants from UCLA revealed that music genres and tastes are correlated to race[6]; and

Whereas, Individual biases for characteristics such as gender, race, and socioeconomic status can further perpetuate disparities[7]; and

Whereas, Current AMA policy H-310.945 emphasizes the AMA's commitment to encouraging residency program directors to unbiasedly evaluate residency program faculty on areas

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reflecting competency such as teaching ability, clinical knowledge, and scholarly contributions; therefore be it

RESOLVED, That our AMA-MSS extend these standards for evaluating residency program faculty to evaluating undergraduate medical students and discourage the consideration of matching social interests, which can lead to unfair bias, between evaluators and undergraduate medical students in clinical evaluations.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Graduate Medical Education Faculty Evaluations H-310.945
The AMA recommends that evaluations of residency program faculty should be done in a confidential manner, at least annually, and the areas evaluated should include teaching ability, clinical knowledge, scholarly contributions, attitudes, interpersonal skills, communication ability and commitment. Residency program directors should provide faculty members with a written summary of the evaluations. (CME Rep. 7, I-93; Reaffirmed and Modified: CME Rep. 2, A-05; Reaffirmed: CME Rep. 9, A-09; Reaffirmed: CME Rep.01, A-19)
Retain; still relevant.

Recommendations for Future Directions for Medical Education H-295.995

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(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(CME Rep.B, A-82; Amended: CLRPD Rep.A, I-92; Res.331, 1-95; Reaffirmed by Res.322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep.2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep.3, A-11; Modified: CME Rep. 01, I-17; Appended: REs. 961, I-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 118
(November 2020)

Introduced by: Varun Aitharaju and Sanjay Jinka, Northeast Ohio Medical University; Alessandra Jimenez, Adaadinchezo Oguejiofor, and Saba Suleman, University of Texas Rio Grande Valley School of Medicine;

Sponsored by: N/A

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Race is a self-identified social construct that results in differential treatment of groups that leads to social inequity on people's health[1,2]; and

Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-identification of their origin or descent, "roots," heritage, or place where the individual or their parents or ancestors were born[3]; and

Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924); and

Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and Chicano/a/x" have been used interchangeably with race in case report[4-7]; and

Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of origin and cultural heritage, constructs which can change over time[8,9]; and

Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based consensus is necessary for optimal use of self-identified race as well as geographical ancestry[10]; and

Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can contribute to the inequitable treatment of patients as it relates to evidence-based medicine[11]; and

Whereas, A current review examining ten studies and over 1.5 million participants demonstrated an association between ethnic minorities including Black, Hispanic, South Asian, Southeast Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency department[12]; and

Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in 2015, there was substantial variation between states in administrative data misclassification of self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native beneficiaries[13]; and

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Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the 62 studies provided complete descriptions of their study populations[14]; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity[15]; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results[16]; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients[16]; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology[16-18]; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women[4]; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women[19]; and

Whereas, it was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences[4]; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care[20]; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, Our AMA “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, the tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias[21]; therefore be it

RESOLVED, That our AMA-MSS send a letter to major journal publishers to issue guidelines for interpreting previous research which define race and ethnicity by outdated means that conflict with the AMA definitions; and be it further

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RESOLVED, That our AMA-MSS affirm policy H-460.924 and pending policy 350.025MSS by asking our AMA-MSS to send a letter to major journal publishers to implement a screening method for future research submissions concerning the incorrect use of race and ethnicity.

Fiscal Note: TBD

Date Received: 08/27/2020

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RELEVANT AMA AND AMA-MSS POLICY:

Code of Medical Ethics 7.1.5

1. Our AMA states that physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly.

Code of Medical Ethics Opinion 8.5

1. States that physicians should examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment
2. States that physicians should support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Racial and Ethnic Disparities in Health Care H-350.974:

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem.
2. Our AMA emphasizes that we need to have a greater awareness for racial disparities, which can be achieved by assessing past studies.

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<u>Reducing Discrimination in the Practice of Medicine and Health Care Education</u> D-350.984:

1. Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism

<u>Improving the Health of Black and Minority Populations</u> H-350.972:

1. Our AMA supports a greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities
2. Our AMA believes this would reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities

<u>Reducing Racial and Ethnic Disparities in Health Care</u> D-350.995:

1. Our AMA supports studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care
2. Our AMA working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities

<u>Strategies for Eliminating Minority Health Care Disparities</u> D-350.996:

1. Our AMA will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

MSS 350.025

1. The MSS works to prevent and combat the influences of racism and bias in innovative health technologies.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 119
(November 2020)

Introduced by: Adam Burton, University of Miami Miller School of Medicine; Carolyn Peterseim, Medical University of South Carolina; Amier Haidar, McGovern Medical School and School of Public Health; Molly Benoit, University of Miami Miller School of Medicine

Sponsored by: N/A

Subject: Amend H-150.927 and H-150.933 to include food products with added sugar

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, From 2000 to 2018, the prevalence of obesity and severe obesity have increased from 30.5% to 42.4%, and from 4.7% to 9.2%, respectively[1]; and

Whereas, The medical costs of obesity continue to rise, and obesity-related conditions, such as heart disease and type 2 diabetes, are some of the leading causes of preventable, premature death[2-3]; and

Whereas, Decreasing excess sugar consumption can play a role in reducing obesity rates[4-5]; and

Whereas, The American Heart Association, U.S. Department of Health and Human Services, World Cancer Research Fund International/American Institute for Cancer Research, and World Health Organization recommend decreasing daily sugar intake among all adults and children[6-8]; and

Whereas, The Food and Drug Administration defines added sugars as sugars that are either added during the processing of foods or are packaged as such, with examples including, but not limited to, brown sugar, corn sweetener, high fructose corn syrup, honey, molasses, raw sugar, and turbinado sugar[9]; and

Whereas, Marketing for processed food with added sugar targets vulnerable populations, especially children and minorities, making it difficult for many individuals to curb their own sugar intake[10-12]; and

Whereas, Children and adolescents are consuming sugar at an alarming rate, with 16% of their total caloric intake from added sugars alone; the CDC recommends children consume 5-15% of total caloric intake from both added sugars and fats combined[13-14]; and

Whereas, Sugar overconsumption in children is linked to negative health outcomes, including micronutrient insufficiency, increased risk of overweight/obesity, insulin resistance, and dental issues[15-16]; and

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Whereas, Lifestyle habits developed in childhood have been shown to persist and exacerbate adulthood obesity, having a lifelong negative health impact[17-18]; and

Whereas, Research shows that poor health behaviors, such as poor diet and smoking among others, in childhood are linked to adverse health outcomes during adulthood, including, but not limited to cancer, heart attack risk, stroke risk, diabetes, and kidney disease[18-19]; and

Whereas, Gaps in federal nutrition policy and sugar and corn industry subsidization have incentivized eating unhealthy foods with added sugars over healthier options and greatly impact the accessibility, affordability, and acceptability of these products[20]; and

Whereas, The recent inclusion of added sugars on the nutrition label could generate substantial health gains and cost savings for the US population via consumer education and stimulating industry reformulation[21]; and

Whereas, Implementing taxes on sugar sweetened beverages (SSBs) has been shown to decrease consumption of SSBs and generate healthcare cost savings[22-24]; and

Whereas, Implementing taxes on sugary foods could be more effective at decreasing obesity rates than implementing taxes on SSBs[25-27]; and

Whereas, Most existing AMA policy only addresses SSBs, leaving gaps in marketing and packaging food products with added sugars[28]; and

Whereas, Roughly one third of added sugar intake is from food products with added sugars[29]; therefore be it

RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

> **Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.927**
> Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption <u>and food products with added sugars</u>, and support evidence-based strategies to reduce the consumption of SSBs <u>and food products with added sugars</u>, including but not limited to, excise taxes on SSBs <u>and food products with added sugars</u>, removing options to purchase SSBs <u>and food products with added sugars</u> in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption <u>and food products with added sugars</u>, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption <u>and food products with added sugars</u>, such as controlling portion sizes; limiting options to purchase or access SSBs <u>and food products with added sugars</u> in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs <u>and food products with added sugars</u> to children; and changes to the agricultural subsidies system; (3) encourages

hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

; and be it further

RESOLVED, That our AMA amend H-150.933, "Taxes on Beverages with Added Sweeteners" by addition to read as follows:

Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

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Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

Taxes on Beverages with Added Sweeteners H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such

as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on **sugar**-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on **sugar**-sweetened beverages as requested.

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or **sugar**, including **sugar**-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

Combating Obesity and Health Disparities H-150.944

Our AMA adopts the following principles related to unanticipated out-of-network care: A) Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider. B) Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans. C) Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur. D) Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians. E) Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. F) Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. G) Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

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2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

Healthful Food Options in Health Care Facilities H-150.949

1. Our AMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of Health Care Facilities.
2. Our AMA hereby calls on all Health Care Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for Health Care Facility cafeterias and inpatient meal menus to publish nutrition information.

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.

2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

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network physicians. E) Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. F) Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. G) Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

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3. Our AMA hereby calls for Health Care Facility cafeterias and inpatient meal menus to publish nutrition information.

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

AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic beverages containing caloric sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition.

Federal Agricultural Subsidy Reform 150.033MSS

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

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Sustainable Food D-150.978

1. Our AMA supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality.
2. Our AMA encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation.
3. Our AMA will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

The Health Effects of High Fructose Syrup D-150.981

1. Our AMA recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS.
2. Our AMA encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response.
3. Our AMA, in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 120
(November 2020)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville.

Sponsored by: N/A

Subject: Supporting Buprenorphine Waiver Training in Undergraduate and Graduate Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The opioid crisis is considered one of the most severe and pressing public health crises we are currently facing and have faced in the history of the United States[1]; and

Whereas, Opioid use disorder (OUD) and misuse of opioids can lead to suffering, disease, and death[2]; and

Whereas, The prevalence of nonmedical use of prescription opioids in the US more than doubled from 1991 to 2013[3]; and

Whereas, Buprenorphine is effective at reducing both the risk of overdose death and the craving for illicit opioids[4]; and

Whereas, A physician is only able to prescribe potentially life-saving medication assisted treatment, such as buprenorphine, after completing buprenorphine waiver training[5]; and

Whereas, Only about 5% of the nation's doctors have the appropriate training/waivers to prescribe buprenorphine to patients[6]; and

Whereas, The most frequent reason for not prescribing buprenorphine among physicians was lack of knowledge and training on use and prescription of the medication[7]; and

Whereas, A study showed that expanding the ability to prescribe buprenorphine has the ability to improve access to opioid treatment like buprenorphine, decrease opioid prescription, and slow the opioid epidemic we currently face[8]; therefore, be it

RESOLVED, That our AMA support the incorporation of buprenorphine waiver training into undergraduate and graduate medical education by amending current policy D-95.972, Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder**,** by addition as follows:

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972

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1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

3. Our AMA supports buprenorphine waiver training incorporation in undergraduate and graduate medical education while this waiver requirement to prescribe buprenorphine exists.

; and, be it further

RESOLVED, That our AMA-MSS further support this addition to medical education by amending current AMA-MSS policy 295.208MSS, Buprenorphine Training in Medical Schools by addition as follows:

295.208MSS Buprenorphine Training in Medical Schools

AMA-MSS supports the standardized buprenorphine waiver training addition in medical school curricula to reduce the patient-provider gap in prescribing medication assisted treatment to those with substance use disorder.

Fiscal Note: TBD

Date Received: 08/01/2020

References:

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RELEVANT AMA AND AMA-MSS POLICY

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Treating Opioid Use Disorder in Hospitals D-95.967
1. Our AMA's Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.
2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.
3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.
4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

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5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being ?a part of the solution? to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Improving Residency Training in the Treatment of Opioid Dependence H-310.906

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Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.

Substance Use and Substance Use Disorders H-95.922
Our AMA:

(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

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

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 121
(November 2020)

Introduced by: Max Zhu, Abraham Shin, Joyce Lee, Boston University School of Medicine.

Sponsored by: N/A

Subject: Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Our AMA supports augmented intelligence (AI) systems that advance the quadruple aim, specifically: (AMA, H-480.939)

(1) To enhance the patient experience of care and outcomes,
(2) To improve population health,
(3) To reduce overall costs for the healthcare system while increasing value,
(4) To support the professional satisfaction of physicians and the healthcare team; and

Whereas, Our AMA seeks to identify opportunities to integrate practicing physicians' perspectives into the development, design, validation, and implementation of health care AI (AMA, H-480.940); and

Whereas, Research from the medical device industry has provided evidence that physicians substantially contribute to medical device innovation, specifically that:

(1) Physicians contributed to a fifth of medical device patents and generated a great number of citations, demonstrating a substantial physician involvement in medical device innovation[1],
(2) Physician patents were cited more times by subsequent patents than those without physician involvement, where the number of citation by follow-on inventions indicate the significance of the original innovation[1],
(3) Physician patents generated more follow-on innovations from a more diverse set of disciplines, emphasizing the broader impact of physician involvement in research[1]; and

Whereas, Research on the implementation of electronic health records (EHRs) has indicated that technology developed with physician involvement is associated with physicians' perceived ease of use and acceptance[2]; and

Whereas, Current research on AI has indicated that:

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(1) Physicians assisted by AI models can outperform physicians or AI alone, specifically in diagnosing metastatic breast cancer and diabetic retinopathy[3, 4],
(2) Physicians can use interactive AI-based technologies in medical image segmentation and identification, providing evidence that physicians and AI technologies can work together to better fulfill the quadruple aim[5]; and

Whereas, Our AMA has launched pathways for healthcare innovation, but these pathways are greatly targeted to physicians currently involved in AI, such as Health 2047, a business that connects our AMA to leading experts in AI and machine learning to produce healthcare solutions[6]; and

Whereas, Our AMA has supported physician innovation, especially in the field of AI, through the Physician Innovation Network (PIN), an online forum board for entrepreneurs to seek medical specialists to "connect the health care innovation ecosystems to improve the development of emerging healthcare technology solutions"[7]; and

Whereas, Early analysis of the PIN has identified that early engagement of physicians and respecting a physician's time and expertise contribute to more meaningful connections between physicians and entrepreneurs[8]; and

Whereas, The PIN currently experiences limited physician utilization, as evidenced by:
(1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a small subset of physicians who have already realized early in their careers that they wish to pursue a nontraditional path in medicine and innovation[9],
(2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1% of our AMA's physician membership base[10]; and

Whereas, Our AMA advocates that our organization, national, and medical specialty societies and state medical associations (AMA, H-480.939):
(1) Leverage medical expertise to ensure clinical validation and assessment of clinical applications of AI systems by practicing physicians,
(2) Outline a new professional role to aid and guide health care AI systems; therefore be it

RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:
(1) Expanding recruitment among AMA physician members,
(2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,
(3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,
(4) Facilitating communication between companies and physicians with similar interests,

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(5) Matching physicians to projects early in their design and testing stages,
(6) Decreasing the time and workload spent by individual physicians on finding projects themselves,
(7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further

RESOLVED, That our AMA supports selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY:

AUGMENTED INTELLIGENCE IN HEALTH CARE, H-480.940

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As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to: 1.Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2.Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3.Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4.Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI. 5.Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to healthcare AI. BOT Rep. 41, A-18

AUGMENTED INTELLIGENCE IN HEALTH CARE H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.

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4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.

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9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it. BOT Rep. 21, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 122
(November 2020)

Introduced by: Deena Abdelhalim, Touro College of Osteopathic Medicine; Alexandria Wellman, Matthew Riley, Jared Hendren, Southern Illinois University School of Medicine; Madeline Jentink, Calley Gober, Midwestern University College of Osteopathic Medicine; Rasa Valiauga, Loyola University Stritch School of Medicine

Sponsored by: Region 1

Subject: Respecting Religious Diversity in Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Diversity embraces race, ethnicity, nationality, and gender and is expanding to encompass sexual orientation, religion, disability, and more[1]; and

Whereas, Respectful inclusion and diversity are integral to the well-being and effectiveness of students, and are essential to delivering appropriate care[2]; and

Whereas, Studies show that students trained at a diverse medical school are more comfortable treating patients from a wide range of backgrounds, in addition to having an enhanced educational experience[3-4]; and

Whereas, Studies show that increased diversity promotes positive attitudes in educational and social environments[5]; and

Whereas, A study found that out of 106 medical schools, 30% utilized peer physical examination, a method of teaching and learning clinical skills where students act as model patients to allow practice of physical examination techniques, such as in osteopathic manipulative medicine and clinical skills courses[6]; and

Whereas, Students may not want to be examined for various reasons that can include religious reasons, childhood abuse or body image concerns and other reasons that should not require disclosure[7]; and

Whereas, Religious students feel uncomfortable with the peer physical exams of intimate body regions because of the association with sexual activity and strictly religious students are significantly less willing to undergo examination of any body part except the hand[8-9]; and

Whereas, 48% of end-of-first year medical students at the University of Minnesota felt exposed when undressed in front of their peers for examination and 12% expressed difficulty ensuring their consent was respected by peers[10]; and

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Whereas, 99% of students were more comfortable examining a partner of the same gender compared to only 70% of students were comfortable with a peer of the opposite gender[10]; and

Whereas, In these peer physical examinations, the student is playing the role of the patient and has a right to informed consent where they can ask questions, express their concerns and request alternative learning approaches[11]; and

Whereas, Several ethical issues were identified regarding these physical examinations and dress codes, which included feelings of coercion and a lack of respect for cultural and religious beliefs[12]; and

Whereas, A study compared students' clinical skills performance after switching from a peer physical examination setting to utilizing standardized patients and found statistically significant increase in the students' grades[13]; therefore be it

RESOLVED, That our AMA should work with appropriate stakeholders to develop inclusive accommodation for students who feel restricted in their religious obligations in peer physical examination courses which include osteopathic manipulative medicine and clinical skills instruction; and

RESOLVED, That our AMA encourage actions by medical schools and work with appropriate stakeholders to provide sufficient accommodations in peer physical examination courses in order to align with student consent and religious obligation.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics 1.1.7: Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

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In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

Conscience Clause: Final Report H-295.896

Principles to guide exemption of medical students from activities based on conscience include the following: (1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues. (2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity. (3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience. (4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies. (5) Policies related to exemption based on conscience should be applied consistently. (6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.

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(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity.

CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08

Code of Medical Ethics Opinion 9.2.5

Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as "patients" are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students' privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:

1. Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
2. Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
3. Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.
4. Allow students the choice of whether to participate prior to entering the classroom.
5. Never require that students provide a reason for their unwillingness to participate.
6. Never penalize students for refusing to participate. Instructors must refrain from evaluating students' overall performance based on their willingness to volunteer as "patients."

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated

against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans,

and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the

termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

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c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

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

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

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

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

allocated to the professional fee component of the total payment received by the contractual arrangement.

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

BOT Rep. 6, I-12, Reaffirmed: CMS Rep. 6, I-13, Modified in lieu of Res. 2, I-13, Modified: Res. 737, A-14, Reaffirmed: BOT Rep. 21, A-16, Reaffirmed: CMS Rep. 05, A-17, Reaffirmed: CMS Rep. 07, A-19, Reaffirmed: CMS Rep. 11, A-19, Modified: BOT Rep. 13, A-19

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14, Reaffirmed in lieu of: Res. 001, I016, Reaffirmation: A-17

Organizations Which Discriminate H-65.988
The AMA (1) encourages holding educational or business meetings or social gatherings in facilities of organizations and clubs which do not refuse membership on the basis of gender, race or religion; and (2) encourages its constituent societies to follow a similar policy.

Res. 62, A-87, Reaffirmed: CLRPD Rep. 3, I-97, Reaffirmed: CEJA Rep. 7, A-07, Reaffirmed: CEJA Rep. 04, A-17

Code of Ethics 9.5.4 Civil Rights & Medical Professionals
Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation,

age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

Issued: 2016

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98, Reaffirmed: CME Rep.2, I-99, Modified: BOT Rep. 11, A-07, Reaffirmed: CME Rep. 9, A-13

Preventing Discrimination against Patients by Medical Students 65.018MSS
AMA-MSS will ask the AMA to oppose the refusal by medical students to treat patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

MSS Res. 4, I-12, Amended AMA Res 1, A-13, Adopted [H-295.865], Reaffirmed: MSS GC Report A, I-16

Addressing Patient Spirituality in Medicine 65.021MSS
AMA-MSS will ask (1) That our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and (2) That our AMA encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals.

MSS Res 14, A-16

Promoting Culturally Competent Health Care 295.081MSS
AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider.

MSS Sub Res 6, I-96, AMA Res 306, A-97 Adopted as Amended [H-295.905], Reaffirmed: MSS Rep B, I-01, Reaffirmed: MSS Rep F, I-06, Reaffirmed: MSS GC Rep D, I-11, Reaffirmed: MSS GC Report A, I-16

Respect for Individual Student's Beliefs 295.082MSS

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AMA-MSS will ask the AMA to encourage medical schools to adopt a policy whereby medical students would be allowed, without penalty, to withdraw from participating in medical procedures that may be violative of personally held moral principles or religious beliefs, provided that the students receive a satisfactory knowledge of the principles associated with the procedure and that the medical schools establish their own guidelines concerning specific procedures and situations in order to avoid the potential of abuse.

MSS Sub Res 7, I-96, AMA Res 304, A-97 Referred, CME Rep 4, A-98 Adopted in Lieu of Res 304 [H-295.896], Reaffirmed: MSS Rep B, I-01, Reaffirmed: MSS Rep F, I-06, Reaffirmed: MSS GC Rep D, I-11, Reaffirmed: MSS GC Report A, I-16

Privacy and Confidentiality of Medical Students in Physical Diagnosis Classes 295.104MSS

AMA-MSS supports the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles:(1) If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without his or her explicit, meaningful, and non-coerced consent; (2) No information regarding abnormal physical findings encountered on a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent.

MSS Late Res 1, I-00, Reaffirmed: MSS Rep E, I-05, Reaffirmed: MSS GC Rep F, I-10, Reaffirmed: MSS GC Rep D, I-15

Medical Student Mistreatment 295.175MSS

AMA-MSS will encourage medical schools to have procedures in place for students to report incidents of mistreatment without fear of retaliation and that instructions on how to report incidents should be explained to students at the beginning of medical school and again before starting rotations.

MSS Res 3, I-13, Reaffirmed: MSS GC Rep A, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 123
(November 2020)

Introduced by: Allison Linehan, Nathalie Abenoza, Christian Hernandez, Medical College of Wisconsin
Sponsored by N/A

Subject: Improving the Use of Medical Interpreter Services by Health Care Providers Through CME
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, There are more than 6,900 known living languages spoken in the world[1]; and

Whereas, More than 66 million Americans speak at least one of over 350 languages other than English at home and more than 25 million Americans speak English "less than very well"[2,3,4]; and

Whereas, Language barriers can have major adverse effects on health such as suboptimal health status; lower likelihood of having regular care providers; lower rates of mammograms, pap smears, and other preventative services; greater likelihood of diagnosis of more severe psychopathology; leaving the hospital against medical advice; and increased risk of drug complications[1,3,5]; and

Whereas, Underuse of a valuable health care resource, professional medical interpretation, can result in these adverse effects and inappropriate care[4]; and

Whereas, Professional medical interpreter services can facilitate effective communication across language differences and increase the delivery of health care to Limited English Proficiency (LEP) patients, yet remain underutilized in health care[3,6]; and

Whereas, Language assistance is a legal right of patients under Title VI of the 1964 Civil Rights Act, therefore hospitals have policies and processes in place, but how they are communicated to front-line staff is variable[5,7]; and

Whereas; One potential contributor is the lack of a designated place within medical training curricula to address language barriers, which calls for a more recognizable and accessible resource for training[5,7]; and

Whereas, In a recent study, only 19% of ED staff had reported prior training on working with interpreters, regardless of the source of training [7]; and

Whereas, Most ED providers and staff who have little training in the use of language assistance were unaware of hospital policy in this area[7,8]; and

Whereas, Dissemination of best practices for the provision of language assistance and the clinical use of non-English language skills has the potential to improve communication with LEP patients[7]; and

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Whereas, Healthcare organizations should ensure that medical professionals across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery or have access to training[9]; and

Whereas, Teaching medical professionals to emphasize the appropriate use of an interpreter is warranted to improve cross-language clinical encounters, and could be executed through a Continuing Medical Education (CME) module[8]; and

Whereas, It has been recommended that healthcare organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-accredited education or other training in Culturally and Linguistically Appropriate Services delivery, or arrange for such education and training to be made available to staff[9]; and

Whereas, CME is a cornerstone of improving competencies and ensuring high-quality patient care by nurses and physicians[10]; and

Whereas, Neither the AMA Ed Hub nor current AMA policy such as H-160.924 address how to appropriately use an interpreter, including skill such as explaining the purpose of the appointment, explaining the interpreter's role, asking questions one at a time, providing information in small, digestible chunks, listening to the patient without unnecessary interruptions, and asking questions to clarify answers if necessary; therefore be it

RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education (CME) module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

Fiscal Note: TBD

Date Received: 08/01/2020

References:

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RELEVANT AMA AND AMA-MSS POLICY

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates. Res. 703, A-17

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. Reaffirmation: A-17

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-382.929

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It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements. Reaffirmation: A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. Reaffirmation: A-17

Study of Interpreter Mandate 160.017MSS
AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English. MSS Res 20, I-10, Reaffirmed: MSS GC Rep D, I-15

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

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

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 124
(November 2020)

Introduced by: Haritha Pavuluri, Tristan Mackey, and Maggie Oliver, University of South Carolina School of Medicine Greenville; Waqas Haque, University of Texas Southwestern Medical School

Sponsored by: N/A

Subject: Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The United States healthcare system is the most expensive in the world and produces worse outcomes than comparable lower-cost health systems[1]; and

Whereas, A 2014 national survey of 600 physicians found that nearly three-quarters of them believe unnecessary tests and procedures represent a serious problem in the healthcare system[7]; and

Whereas, Excessive testing and treatment has been attributed to over $200 billion in wasted spending with mistakes or injuries leading to 30,000 deaths[13]; and

Whereas, Studies have shown that physicians whose residencies were in higher-spending regions spent 29% more on average on medical care for their patients than their peers who had trained in lower-spending areas of the country[2]; and

Whereas, The increased spending on medical care was shown to persist even if the new physicians went to another region of the country with lower health care spending, and mean spending for physicians trained in residency programs with higher-cost patient care averaged $522 more per Medicare patient each year[2]; and

Whereas, These higher-cost practice traits persisted until they appeared to level off at mid-career - around 16 to 19 years after residency - suggesting that interventions during residency training may have the potential to help control future health care spending[2]; and

Whereas, The Choosing Wisely campaign is an international campaign developed by and for physicians, with the primary aim of providing care that is “supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary”[6]; and

Whereas, A 2014 survey of 600 physicians found that physicians with exposure to the Choosing Wisely Campaign were 17 percent more likely to have reduced the number of tests or procedures performed in the last 12 months[7]; and

Whereas, Following Choosing Wisely recommendations in infectious disease treatment would reduce potential harm to patients and increase the value of healthcare when implemented[3]; and

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Whereas, Choosing Wisely recommendations serve to improve quality and optimize both clinical outcomes and resource utilization in newborn care[4]; and

Whereas, Implementation of a Choosing Wisely campaign across 25 medical offices serving approximately 300,000 members led to a sustained reduction in non-beneficial services in ambulatory care, including reduced use of complete blood counts (CBCs) and electrocardiograms (EKGs) as routine screening tests in physical examination visits, age-inappropriate dual-energy x-ray absorptiometry (DEXA) scans, and imaging for uncomplicated headache[8]; and

Whereas, Choosing Wisely recommendations facilitate prudent care decisions, reducing unnecessary health care spending and preventing harm in the field of nephrology[5]; and

Whereas, A quality initiative based on Choosing Wisely recommendations implemented in three internal medicine residencies led to a 50% decrease in median blood test count, a decrease in median length of hospital stay, and decreased percentage of patients requiring transfusions[9]; and

Whereas, A high value care curriculum for interns in an internal medicine residency program, consisting of six seminars based on sources including the Choosing Wisely campaign, was rated as highly useful by interns (mean score 4.4/5) with a significant improvement in their self-rated knowledge, skills, and attitudes regarding high value patient care[10]; and

Whereas, A 45-minute morning report on high value care delivered to academic internal medicine trainees was described as educationally valuable by 96% of attendees, and resulted in a significant increase in the trainees' self-reported understanding of the cost for diagnostic tests and in the likelihood that costs of diagnostic tests would affect their future ordering practices[11]; and

Whereas, Incorporation of evidence-based imaging curriculum using the American College of Radiology (ACR) Appropriateness Criteria (which overlap with Choosing Wisely recommendations from ACR) into a radiology clerkship found that a majority of medical students were unaware of this resource prior to the educational sessions, and 89% reported a solid understanding of indications for imaging tests and a likelihood of using them in future practice after the sessions[12]; and

Whereas, A gap in undergraduate medical education has been acknowledged with regard to resource-stewardship education[15]; and

Whereas, 60% of medical students surveyed in a study reported that the inclusion of Choosing Wisely concepts improved their ability to develop a management plan[14]; and

Whereas, Our AMA currently supports the concepts of the Choosing Wisely program (AMA Policy D-155.988); and

Whereas, Our AMA supports choosing the course of action that requires fewer resources with similar likelihood and degree of anticipated benefit, and that physicians have the training they need to be informed about health care costs (Physician Stewardship of Health Care Resources 11.1.2); and

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Whereas, Our AMA supports value-based health care, and cost reduction, but has no policy on the importance of including this in medical education (Physician Stewardship of Health Care Resources 11.1.2); therefore be it

RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the "Choosing Wisely" Program by insertion as follows:

> **Support for the concepts of the "Choosing Wisely" Program, D-155.988**
>
> 1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.
>
> 2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program in undergraduate and graduate medical education.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Support for the Concepts of the Choosing Wisely Program D-155.988
Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

Physician Stewardship of Health Care Resources 11.1.2
Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.

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(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
(2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and
(3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

295.115MSS: Support of Business of Medicine Education for Medical Students
AMA-MSS will ask the AMA to encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (MSS Res 1, I-03) (AMA Res 305, A-04 Adopted [D-295.958]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-295.958 Rescinded: CME Rep. 2, A-14)

295.177MSS: Shared Decision-Making in Medical Education
AMA-MSS will ask the AMA to (1) amend policy D.373.999 by insertion as follows: D-373.999 Informed Patient Choice and Shared Decision Making (1) Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care; and (2) Collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids. (MSS Res 21, I13)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 125
(November 2020)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Jennifer Gaertner-Otto, University of the Incarnate Word School of Osteopathic Medicine; Imaima Casubhoy, University of Missouri Kansas City School of Medicine; Abby Dillaha, University of Cincinnati College of Medicine; Waqas Haque, University of Texas Southwestern Medical School

Sponsored by: Region 4, Region 5

Subject: Transparency on Restrictions of Care

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Catholic hospitals are required to adhere to "Ethical and Religious Directives for Catholic Health Care Services", which ban sterilization, contraception, and allow for abortion only in cases where there is zero alternative to saving maternal life[1]; and

Whereas, under the Ethical and Religious Directives for Catholic Health Care Services, physicians at these institutions are unable to promote restricted services, including reproductive care and end of life care, leading to a restriction on referrals for patients[1]; and

Whereas, The Public Health Service Act of 1996 prohibits state or local government from discriminating against health care entities that refuse to undergo training in abortion procedures, refuse to provide trainings, or refuse to make arrangements or referrals for such procedures[2]; and

Whereas, 38.7% of US reproductive-aged women reside in counties with high or dominant Catholic hospital market share[3]; and

Whereas, In 2016, Catholic hospitals consisted of 14.5% of all U.S. hospitals, comprising 30 to 39% of acute care hospitals in 5 states and over 40% of hospitals in five other states[4,5]; and

Whereas, 21% of Catholic-affiliated hospitals in the United States did "not explicitly disclose their religious identity on their website, and only 28% specified how religious affiliation might influence patient care"[4,5]; and

Whereas, 14.7% of Catholic-affiliated hospitals provide a link to their directives regarding care restrictions on their website, and only 4.3% provide a list of services when a directive is not available[4,5];and

Whereas, A 2018 survey shows that more than one-third of women who go to a Catholic hospital as their primary hospital for reproductive care are unaware of its Catholic affiliation[6]; and

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Whereas, A nationally representative AmeriSpeak survey showed that 80.7% of women feel that it is important to know what services are not provided at a hospital due to an institution's religious or moral beliefs[1]; and

Whereas, Some hospitals state that patients are only provided information about reproductive services if requested by the patient[7]; and

Whereas, Obstetric hospital care payments are typically made by Medicaid or employer insurance, giving patients a limited choice in hospitals[1]; and

Whereas, 38.7% of US reproductive-aged women reside in counties with high or dominant Catholic hospital market share, restricting access to reproductive care geographically[7]; and

Whereas, A lack of transparency can translate into economic hardship for patients if the only hospital in their medical insurance plan is one that adheres to the "Ethical and Religious Directives for Catholic Health Care Services", resulting in high out of network costs for necessary care not provided by the hospital[1]; and

Whereas, AMA Code of Medical Ethics 11.2.6 discusses the need for physician-leaders within institutions to "be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services," but does not explicitly state institutions should be transparent themselves; and

Whereas, AMA Code of Medical Ethics 1.1.7 recommends physicians should "refer a patient to another physician or institution to provide treatment the physician declines to offer…[and] offer impartial guidance to patients about how to inform themselves regarding access to desired services" but does not require this of institutions who decline to perform services; and

Whereas, 10% of obstetrics and gynecology residency training programs occur solely at hospitals that adhere to "Ethical and Religious Directives for Catholic Health Care Services", limiting necessary medical skills that trainees are able to learn[1]; and

Whereas, In 2019, the state of Washington enacted a law requiring "the Department of Health to create a simple form of reproductive health care services for hospitals to fill out, post on their website, and submit to a Department of Health webpage…[to include] reproductive health services related to abortion, contraception, pregnancy, infertility, STDS and HIV[8,9]; therefore be it

RESOLVED, That our AMA-MSS amend policy AMA-MSS 5.066 Reproductive Health Care in Religiously-Affiliated Hospitals as follows:

> **AMA-MSS 5.066 ~~Reproductive Health Care in Religiously-Affiliated Hospitals~~ Transparency on Restrictions of Care**
>
> AMA-MSS (1) advocates that all ~~religiously-affiliated~~ medical institutions provide medically
> accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms

of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; and (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient. (3) advocates that all facilities and hospitals disclose all restrictions in care, including reproductive care and end of life care, to all patients seeking care at their facility, all trainees considering training programs at their facility, and all physicians seeking employment at their facility. ; and be it further

RESOLVED, That our AMA amend the following Code of Ethics Policy 1.1.7,

"(d) Recognize that physicians' primary obligation is to their patients, and promote transparency between hospitals and employed healthcare professionals as to permissible and prohibited services at the facility.

(f) Physicians should refer a patient to another physician or institution to provide treatment the physician or their affiliated group/employed health-system declines to offer. Institutions should not be able to prevent physicians from providing referrals to patients for services not provided at the facility. ; and be it further

RESOLVED, That our AMA-MSS forward internal policy 5.006MSS to the AMA House of Delegates as amended, as well as the remainder of this resolution.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

- AMA-MSS 5.066
- 10.7 Code of Medical Ethics: Ethics Committees in Healthcare Institutions
- 11.2.6 Code of Medical Ethics: Mergers of Secular and Religiously Affiliated Health Care Institutions
- H-295.896: Conscience Clause – Final Report
- 1.1.7 Code of Medical Ethics: Physician Exercise of Conscience

AMA-MSS 5.066

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

10.7 Code of Medical Ethics:

In making decisions about health care, patients, families, and physicians and other health care professionals often face difficult, potentially life-changing situations. Such situations can raise ethically challenging questions about what would be the most appropriate or preferred course of action. Ethics committees, or similar institutional mechanisms, offer assistance in addressing ethical issues that arise in patient care and facilitate sound decision making that respects participants' values, concerns, and interests. In addition to facilitating decision making in individual cases (as a committee or through the activities of individual members functioning as

ethics consultants), many ethics committees assist ethics-related educational programming and policy development within their institutions. To be effective in providing the intended support and guidance in any of these capacities, ethics committees should:
(a) Serve as advisors and educators rather than decision makers. Patients, physicians and other health care professionals, health care administrators, and other stakeholders should not be required to accept committee recommendations. Physicians and other institutional stakeholders should explain their reasoning when they choose not to follow the committee's recommendations in an individual case.
(b) Respect the rights and privacy of all participants and the privacy of committee deliberations and take appropriate steps to protect the confidentiality of information disclosed during the discussions.
(c) Ensure that all stakeholders have timely access to the committee's services for facilitating decision making in nonemergent situations and as feasible for urgent consultations.
(d) Be structured, staffed, and supported appropriately to meet the needs of the institution and its patient population. Committee membership should represent diverse perspectives, expertise, and experience, including one or more community representatives.
(e) Adopt and adhere to policies and procedures governing the committee and, where appropriate, the activities of individual members as ethics consultants, in keeping with medical staff by-laws. This includes standards for resolving competing responsibilities and for documenting committee recommendations in the patient's medical record when facilitating decision making in individual cases.
(f) Draw on the resources of appropriate professional organizations, including guidance from national specialty societies, to inform committee recommendations.
Ethics committees that serve faith-based or other mission-driven heath care institutions have a dual responsibility to:
(g) Uphold the principles to which the institution is committed.
(h) Make clear to patients, physicians, and other stakeholders that the institution's defining principles will inform the committee's recommendations.

11.2.6 Mergers of Secular and Religiously Affiliated Health Care Institutions

The **merger** of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity. Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.
Physician-leaders within institutions that have or are contemplating a **merger** of secular and faith-based institutions should:
(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the same breadth of services and care previously offered will continue to be available to the community.
(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

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(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.
(d) Recognize that physicians' primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.
Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:
(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.
(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

Conscience Clause: Final Report H-295.896

Principles to guide exemption of medical students from activities based on conscience include the following:
(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' **religious** or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.
(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.
(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
(5) Policies related to exemption based on conscience should be applied consistently.
(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.
(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity.

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1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 126
(November 2020)

Introduced by: Avi Levy, Annie Huang, Hira Ali, Midwestern University Arizona College of Osteopathic Medicine; Corey Hamel, Touro College of Osteopathic Medicine - Middletown

Sponsored by: N/A

Subject: Implementation of a single licensing exam for medical students

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) is a licensing exam series that is currently required by the Commission on Osteopathic College Accreditation (COCA) to be taken by all osteopathic medical students in order to graduate from a COCA accredited medical school [1]; and

Whereas, the United States Medical Licensing Exam (USMLE) is a licensing exam series that is currently taken by allopathic medical students and many osteopathic medical students [2]; and

Whereas, the American Osteopathic Association offers a pathway of board certification for allopathic physicians who did not attend a COCA accredited medical school, recognizing that the practice of osteopathic medicine is not defined by taking the COMLEX [3]; and

Whereas, almost 20% of ACGME program directors do not utilize the COMLEX as part of the residency selection process, which puts osteopathic medical students that do not take the USMLE at a significant disadvantage [4]; and

Whereas, a study published in the Western Journal of Emergency Medicine found “that [osteopathic medical] students who reported USMLE [scores] were more likely to match [into emergency medicine]. [Osteopathic] students applying to allopathic [emergency medicine] programs should consider taking [the] USMLE to improve their chances of a successful match [5];” and

Whereas, many residency programs require USMLE scores from osteopathic applicants in order to be considered for residency [6]; and

Whereas, there is a “strong association between COMLEX Level 1 and USMLE Step 1 performance [7];” and

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Whereas, the Student Osteopathic Medical Association, resolved to advocate to COCA to remove their requirement that the COMLEX be taken by osteopathic medical students in order to graduate from a COCA accredited medical school [8]; and

Whereas, having two licensing exam series for osteopathic and allopathic students fragments the way medical education is assessed and creates an opportunity to evaluate osteopathic and allopathic students differently.

Whereas, osteopathic students who are encouraged the take the USMLE have to incur the costs of taking two licensing exam series in addition to the high cost of attending medical school; and

Whereas, our AMA supports “the movement toward a unified and standardized residency application and match system (D-310.977);” and

Whereas, our AMA discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training (H-295.876); therefore be it

RESOLVED, our AMA support allowing osteopathic medical students to take the United States Medical Licensing Exam (USMLE) series and an osteopathic specific subject test, in lieu of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) series; and be it further

RESOLVED, our AMA will study the impact and plausibility of implementing a single licensing exam series for medical students who attend Commission on Osteopathic College Accreditation (COCA) and Liaison Committee on Medical Education (LCME) accredited schools, where osteopathic medical students are required to take an osteopathic specific subject test instead of a separate licensing exam series.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876
1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.

2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.

Medical Specialty Board Certification Standards H-275.926
Our AMA:
(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to

practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Alignment of Accreditation Across the Medical Education Continuum H-295.862
1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six

competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools.

2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.

3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.

4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.

5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools

should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

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(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory

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authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

Equality for COMLEX and USMLE 275.013MSS
AMA-MSS will ask the AMA to (1) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (2) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (3) work with Residency Program Directors to

promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (MSS Res 38, A-18)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 127
(November 2020)

Introduced by: Mir Ali, UT Southwestern Medical School

Sponsored by: N/A

Subject: Supporting improved public understanding of plastic surgery board certification.

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The AMA endorses that physicians have a social contract to maintain professional competency[1] and ensure patient safety and quality care is provided;[2] and

Whereas, The majority of state medical boards do not allow the performance or delegation of surgical cosmetic procedures to an individual who is not an appropriately licensed surgeon practicing within the scope of practice provided by such a license;[3] and

Whereas, The American Board of Plastic Surgery (ABPS) is the only board accredited by the American Board of Medical Specialties (ABMS) that allows physicians to practice cosmetic surgery, however, multiple self-designated medical boards claim to certify physicians in cosmetic surgical procedures, allowing these physicians to advertise themselves as “board-certified” with as little as one year of training in cosmetic surgery and provide patients with a false sense of trust in their surgical competence;[4, 5, 6] and

Whereas, the Medical Practice Act, supported by the AMA, states that an individual commits a prohibited practice if they advertise themselves in a way that could be considered false, misleading, or deceptive;[7] and

Whereas, the AMA Truth in Advertising Campaign encourages state medical societies to advocate that health care providers clearly and honestly state their level of training, education, and licensing to patients;[8] and

Whereas, The AMA adopts the standard that patient safety and quality are paramount, thus patients should be assured that individuals who perform surgical procedures are appropriately trained physicians;[2] and

Whereas, a 2017 study from *Plastic and Reconstructive Surgery* indicated that 70.8% of cosmetic surgery patients are unaware of the differences in training requirements between ABPS diplomates and diplomates from self-designated boards;[4] and

Whereas, a 2018 study from *Aesthetic Surgery Journal* indicated that only 17.8% of the top 163 plastic surgery-posts on Instagram were from plastic surgeons certified by the ABPS and that 67.1% of these posts were self-promotional as opposed to educational;[9] and
Whereas, the American Society of Plastic Surgeons’ “Do Your Homework” campaign endeavors

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to help educate the public on how to correctly identify an ABPS board-certified plastic surgeon, but misperceptions among the patient populace still remain regarding who can safely perform plastic surgery;[4] therefore be it

RESOLVED, That our AMA affirm its support for efforts to inform patients of the difference in training requirements between ABPS board-certified plastic surgeons and individuals board-certified through self-designated medical boards; and be it further

RESOLVED, That our AMA affirm its advocacy for appropriate scope of practice by discouraging non-ABPS certified individuals from advertising themselves as board-certified plastic surgeons and performing plastic surgery procedures.

Fiscal Note: TBD

Date Received: 08/01/2020

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8. American Medical Association. Policy Compendium. Truth in Advertising H-405.964.
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RELEVANT AMA AND AMA-MSS POLICY

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY:
MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in

a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

(4) Apply our knowledge and skills when needed, though doing so may put us at risk.

(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

(7) Educate the public and polity about present and future threats to the health of humanity.

(8) Advocate for **social**, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

(9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.
CEJA Rep. 5, I-01; Reaffirmed: CEJA Rep. 04, A-17

Definition of Surgery H-475.983

Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means.

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Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.
Res 212, A-07; Reaffirmed: Rep 16, A-13

Truth in Advertising H-405.964

1. AMA policy is that any published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements.

2. Our AMA opposes any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses.
Res 9, A-02; Appended: Res. 228, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 128
(November 2020)

Introduced by: Elise Tidwell, Alex Johar, Creighton University School of Medicine.

Sponsored by: Region 2

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have undergone a previous cesarean section undergo trial of vaginal birth; and

Whereas, Many hospitals ban the practice of TOLAC[1-3]; and

Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections because women eligible for vaginal birth are not given the opportunity for TOLAC[4]; and

Whereas, women may have to travel far distances to find a hospital or provider that is willing to let them attempt TOLAC[5]; and

Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all United States births in 2017[6-8]; and

Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm delivery for future pregnancies[9]; and

Whereas, Vaginal births result in decreased rates of respiratory distress and other complications for newborns as compared to cesarean section births[10,11]; and

Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%[12]; and

Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection between women undergoing TOLAC versus ERCD[12]; and

Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for women with no contraindications[13]; and

Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at hospitals that provide at least basic maternal care[14,15]; and

Whereas, TOLAC is a viable alternative to cesarean section that should be considered during the antepartum course of care and be part of the physician-patient decision process[16]; and

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Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment allows patients control and autonomy over their healthcare decisions; and

Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients[3,17]; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our AMA encourage hospitals that can at least provide basic maternal care as defined by American College of Obstetrics and Gynecology not to ban trial of labor after cesarean to protect the shared decision-making process between patient and physician; and be it further

RESOLVED, That our AMA encourage hospitals that do not feel they have resources to perform TOLAC to assist in the transfer of care of patients who desire trial of labor after cesarean to a hospital that is equipped to perform trial of labor after cesarean; and be it further

RESOLVED, That our AMA encourage hospitals to publish their trial of labor after cesarean policies to allow patients to make informed maternal healthcare decisions.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A **patient-physician** relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited **patient-physician** relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

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(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited **patient-physician** relationship exists.

AMA Principles of Medical Ethics: I,II,IV,VIII

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.

Code of Medical Ethics Opinion 1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between **patient** and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example. Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' **rights**. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.

(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the **patient** based on the physician's objective professional judgment.

(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.

(d) To make decisions about the care the physician recommends and to have those decisions respected. A **patient** who has decision-making capacity may accept or refuse any recommended medical intervention.

(e) To have the physician and other staff respect the **patient**'s privacy and confidentiality.

(f) To obtain copies or summaries of their medical records.

(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I,IV,V,VIII,IX

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

Issued: 2016

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives. Res. 23, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10

Shared Decision-Making H-373.997

Our AMA:

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1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.

CMS Rep. 7, A-10. Reaffirmed in lieu of Res. 5, A-12Reaffirmation I-14Reaffirmed: CMS Rep. 06, A-19

420.006MSS High Rates of Cesarean Deliveries

AMA-MSS will ask the AMA to (1) support the American Congress of Obstetricians and Gynecologists' opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and (2) encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use. (MSS Res 10, I-13) (AMA Res 706, A-14 Not Adopted) (Amended and Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 129
(November 2020)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Imaima Casubhoy, University of Missouri Kansas City School of Medicine

Sponsored by: Region 2

Subject: Guidelines on Chaperones for Sensitive Exams

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Estimates indicate that almost 11 percent of provider misconduct reports are sexual in nature[1]; and

Whereas, Rigorous published studies conclude that we lack sufficient information on malpractice to accurately establish the rates and types of physician misconduct[2]; and

Whereas, The presence of medical chaperones is a common practice during sensitive exams for patients[3,4]; and

Whereas, Physicians can be reported for alleged misconduct that never occured, but is difficult to disprove without witnesses[5]; and

Whereas, University of Michigan policy states that “A chaperone’s presence may also provide protection to health professionals against unfounded allegations of improper behavior, and a health professional should be able request a chaperone for any examination or procedure”[6]; and

Whereas, A study investigating whether medical chaperones affect patient satisfaction had results indicating that 61% of adolescent patients preferred to be offered a chaperone[3,4]; and

Whereas, American College of Obstetricians and Gynecologists (ACOG) recommends, in part, accommodating patient requests for a chaperone, regardless of the physician's gender[7]; and

Whereas, The American College of Physicians Ethics Manual states that “in general, the more intimate the examination, the more the physician is encouraged to offer the presence of a chaperone.”[8]; and

Whereas, Pediatric patients, disabled patients, patients with judgement-altering health conditions, patients who lack the capacity to give informed consent, are unable to protect themself from abuse, neglect or exploitation, and patients who lack momentary capacity are vulnerable to potential misconduct and may be unable to request a chaperone; and

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Whereas, Some institutions require formally trained chaperones, including 7 states implementing legal mandates for the presence of medical chaperones during sensitive physical exams[9-13]; and

Whereas, Requiring a chaperone for every single sensitive exam may place a greater burden on staff and increase health care costs, and thus should not be institutionally mandated for every exam; and

Whereas, Patients may not want an extra person present for sensitive examinations due to the private nature of such examinations, and thus an opt-in/opt-out policy is more preferable to a fully mandated policy[14]; and

Whereas, Documentation of patient interaction has been shown to decrease rates of litigation ruled against providers[15]; and

Whereas, Patients may be uncomfortable requesting a chaperone when the provider asks themselves due to intimidation or fear of undermining the trust in the patient-provider relationship, and a study found that 54% of patients preferred to have the nurse ask about chaperone preference rather than the physician [5]; and

Whereas, Chaperones may feel uncertain or concerned about intervening during an inappropriate exam or reporting potential misconduct, especially if they are hierarchically inferior to the provider, calling for a need for educating chaperones on proper conduct[13]; and

Whereas, AMA policy states says any authorized member of the health care team can serve as a medical chaperone as long as there are clear expectations to uphold professional standards of privacy and confidentiality, failing to address potential discomfort a chaperone may have in reporting egregious behavior during exams; and

Whereas, there have been instances of litigation when patient declined a chaperone during an exam[16]; and

Whereas, Physicians may feel uncomfortable performing sensitive exams on patients without a chaperone due to fear of litigation or discomfort with patient conduct during an exam; and

Whereas, American Association of Family Physicians (AAFP) Policy suggests that providers should not allow the process of ensuring that an exam is chaperoned to interfere with appropriate and timely patient care and clinical judgment.

Whereas, AMA and ACOG policy have extensive protection guidelines for patients, but do not include guidelines to protect physicians[17]; therefore be it

RESOLVED, That our AMA amend policy 1.2.4 Use of Chaperones in Code of Medical Ethics by addition as follows:

> Code of Ethics 1.2.4 Use of Chaperones
>
> Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly

explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

Physicians should:

(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients. Ensure patients are educated about the role of the chaperone and chaperone policy.

(b) Always honor a patient's request to have a chaperone and explicitly offer chaperones for patients of all genders and sexual orientations during sensitive exams.

(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.

(d) In general, use a chaperone even when a patient's trusted companion is present.

(e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

(f) Aim to document in every patient's chart his or her preference regarding chaperones before such exams are performed.

(g) Aim to document all sensitive encounters involving chaperones in the health record, including names, time, and date. If a patient declines a chaperone, this should also be noted. If a patient with decision-making capacity declines a part of or the whole examination, it should not be done. The refusal should be noted in the chart.

(h) Encourage nurse/desk staff to document patient preference before the patient encounters the physician rather than having the provider ask themselves.

(i) Encourage use of chaperones in cases where a patient declines a chaperone but the physician still feels uncomfortable, allowing the provider to defer the exam to another day or to another physician or chaperone, with reassurance to the patient that this is standard practice.

(j) Encourage formal training for all chaperones including when to report and how to report.

(k) Not allow the process of ensuring that an exam is chaperoned to interfere with appropriate and timely patient care and clinical judgment.

(l) Ensure that a chaperone is present for all vulnerable patients.

Fiscal Note: TBD

Date Received: 08/01/2020

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RELEVANT AMA AND AMA-MSS POLICY

1.2.4 Use of Chaperones

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

Physicians should:

(a) Adopt a policy that patients are free to request a **chaperone** and ensure that the policy is communicated to patients.

(b) Always honor a patient's request to have a **chaperone**.

(c) Have an authorized member of the health care team serve as a **chaperone**. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.

(d) In general, use a **chaperone** even when a patient's trusted companion is present.

(e) Provide opportunity for private conversation with the patient without the **chaperone** present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 130
(November 2020)

Introduced by: Yomna Amer, University of Louisville School of Medicine;
Morgan Haynes, University of New Mexico School of Medicine.
Sponsored by: N/A
Subject: Protection From Risks Of Indoor Tanning
Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The dangers of excess ultraviolet radiation are undeniable and include the development of melanoma and non-melanoma skin cancer, cataracts and premature aging[1]; and

Whereas, The Food and Drug Administration notes that the risk of melanoma of the skin increases by 75 percent when tanning bed use is started before the age of 35[2]; and

Whereas, Skin cancers caused by indoor tanning are responsible for $343 million a year in direct medical costs for patients in the United States[3]; and

Whereas, In 2009 the World Health Organization declared tanning bed radiation as a Category 1 carcinogen, similar to tobacco and alcoholic beverages which both have age-restrictions limiting purchase and consumption[4,5]; and

Whereas, Per Food and Drug Administration guidelines, all sunlamp products must now contain "black box" warnings stating that they should not be used by individuals under the age of 18[6]; and

Whereas, current AMA policy on updating health curricula on the hazards of exposure to tanning rays does not prevent the eminent harm while some minors disregard said health recommendations; and

Whereas, Tanning salon compliance with current state laws restricting access to minors or requiring parental consent are unsatisfactory and putting minors at risk[7]; therefore be it

RESOLVED, That the AMA-MSS amend current policy and support emphasizing the causal relationship of tanning beds use and the increase in skin cancer rates, and support of the recommendations of the American Academy of Dermatology and public health organizations; and further be it

RESOLVED, That the AMA-MSS support a complete ban of minors' utilization of indoor tanning.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

H-440.839: Protecting the Public from Dangers of Ultraviolet Radiation

TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

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H-55.972: Early Detection and Prevention of Skin Cancer
Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

440.004MSS: Education on the harmful effects of UVA and UVB light
Education on the Harmful Effects of UVA and UVB Light: AMA-MSS will ask the AMA to assemble and disseminate information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers. (AMA Res 162, A-84 Adopted [H-440.980]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-440.980 Rescinded: CCB/CLRPD Rep. 3, A-14) (Reaffirmed: MSS GC Rep D, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 131
(November 2020)

Introduced by: Alexandria Wellman, Matthew Riley, Southern Illinois University School of Medicine; Madeline Jentink, Midwestern University College of Osteopathic Medicine

Sponsored by: Association of Native American Medical Students

Subject: Advocating against medical students as a source of profit for medical licensure examinations

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, The National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) require medical students and residents to purchase four examinations in order to complete their training[1]; and

Whereas, The purchase of these examinations with loan money substantially increases the amount paid by trainees[1]; and

Whereas, The cost of the Step 2 Clinical Skills examination alone costs medical students in the United States and Canada $20.4 million per annum, which increases to $56.4 million at compounded interest at a rate of 6.8%[1]; and

Whereas, The standard inflation discount rate of 3% adjusts the 15-year cost of the Step 2 Clinical Skills examination to $36.2 million annually in 2012[1]; and

Whereas, The median student debt accrued at graduation has increased by 220% from 1992 to 2017 after accounting for inflation for medical students in the United States from $50,000 in 1992 and rising to $192,000 in 2017[2]; and

Whereas, Increasing level of medical student debt level is associated with poor academic performance and mental health, as well as alcohol abuse and dependence[2]; and

Whereas, In 2017, The NBME had a revenue of $153.9 million, and net assets of $177.6 million[3]; and

Whereas, The authors recognize that NBME is a valued partner to the AMA, and would like the AMA and NBME to maintain a business relationship that is beneficial to the education of current and future physicians; therefore be it

RESOLVED, That our AMA advocate against the use of current students or graduates of AAMC LCME-accredited medical schools as a source of profit for medical licensure examinations; and be it further

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RESOLVED, That our AMA advocate for medical licensure examinations and related study, practice examinations, and examination preparatory materials released by the National Board of Medical Examiners to be available at a cost to American medical students that does not exceed the cost of services to provide the examination with no net profit from the medical student's examination fees; and be it further

RESOLVED, That our AMA will work to reasonably decrease costs incurred by medical students for their education and training; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates.

Fiscal Note: TBD

Date Received: 09/20/2020

References:

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RELEVANT AMA AND AMA-MSS POLICY

Clinical Skills Training in Medical Schools D-295.960

Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates. Res. 324, A-03, Appended: Res. 309, A-11, Appended: Res. 904, I-13

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the

USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. CME Rep. 8, A-99, Reaffirmed: CME Rep. 4, I-01, Reaffirmed: CME Rep. 2, A-11, Modified: CME Rep. 2, A-12

Independent Regulation of Physician Licensing Exams D-295.939

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). CME Rep. 10, A-08, Modified; CME Rep. 01, A-18

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making

permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial

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advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

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

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice. CME Report 05, I-18, Appended: Res. 953, I-18, Reaffirmation: A-19, Appended: Res. 316, A-19

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.

2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.

3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new

and improved methods of assessing medical student competence for advancement into residency.

4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.

6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.

7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. CME Rep. 7, I-99, Reaffirmed: CME Rep. 2, A-09, Appended: Alt. Res. 311, A-16, Appended: CME Rep. 9, A-17, Reaffirmation: I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 132
(November 2020)

Introduced by: Isiah Gonzalez; Diana Palacios, Long School of Medicine at the UT Health Science Center

Sponsored by: N/A

Subject: Advocacy for “Breast Implant Illness” Patients

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, “Breast implant illness” refers to an ill-defined cluster of systemic symptoms including myalgias, arthralgias, chronic fatigue, neurological manifestations, and cognitive impairment occurring after breast implants have been placed[1]; and

Whereas, There are a large number of patients at risk for “breast implant illness,” as there has been an increase in breast augmentation surgery of 41% over the last twenty years, amounting to 212,000 in the year 2000 and 299,715 in 2019[2]; and

Whereas, In August of 2020, the United States Food and Drug Administration reported receiving 2,497 medical device reports containing symptoms consistent with “breast implant illness” from November 2018 to October 2019[3]; and

Whereas, In 2019, The United States Food and Drug Administration called for the improvement of breast implant warning labeling, citing “breast implant illness” as one of the risks associated[4]; and

Whereas, There has been a stark increase in support groups and public interest in “breast implant illness,” with over 122,000 individuals reporting a range of symptoms that they attribute to their breast implants[5]; and

Whereas, Literature over the past few decades suggest many patients complaining of “breast implant illness” have often been dismissed, with their symptoms and experiences explained away as somatization, leaving the problem unaddressed[6]; and

Whereas, Recent research indicates that patients suffering from symptoms consistent with “breast implant illness” have significant and sustained improvement of symptoms after explant, with journals citing up to 84% of patients reporting partial or complete resolution of symptoms postoperatively[7,8]; and

Whereas, Most major insurance providers, such as Aetna and Cigna currently do not cover breast explant surgery in patients with symptoms consistent with “breast implant illness”[9,10]; and
Whereas, There is a lack of peer-reviewed research regarding the phenomenon of “breast implant illness,” with current evidence supporting the value of further investigation[1]; and

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Whereas, Current AMA policy (H-55.973, H-55.977 and H-525.984) does not address the issue of “breast implant illness,” or breast explant surgery, but does promote patients be fully informed about the risks and benefits associated with breast implants; therefore be it

RESOLVED, That our AMA supports research by the appropriate stakeholders to investigate the etiology of the symptoms termed “breast implant illness” in order to definitively establish or discredit “breast implant illness” as a medically diagnosable syndrome; and be it further

RESOLVED, That our AMA encourages physicians to discuss breast implant explantation as a treatment option in cases where patients exhibit symptoms consistent with “breast implant illness”; and be it further

RESOLVED, That our AMA advocates for patients suffering from the systemic symptoms consistent with “breast implant illness” by promoting awareness through the dissemination of relevant scientific information to the public.

Fiscal Note: TBD

Date Received: 09/20/2020

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RELEVANT AMA AND AMA-MSS POLICY

Breast Reconstruction H-55.973
Our AMA: (1) believes that reconstruction of the breast for post-treatment rehabilitation of patients with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or salpingo-oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. CCB/CLRPD Rep. 3, A-1; Modified: Res. 912, I-18

Breast Implants H-525.984
Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated. CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12

Male Breast Cancer H-55.977
Our AMA: (1) recognizes that breast cancer is a condition that affects males as well as females; (2) recognizes that men who carry a known BRCA mutation, have a strong family history of cancer (especially male breast cancer), have a personal history of breast cancer, or have an altered estrogen-testosterone ratio are at increased risk of developing male breast cancer; (3) supports the utilization of heightened surveillance methods when indicated, and consideration of genetic testing when appropriate, in men who are at increased risk of developing breast cancer; (4) supports physician and patient education about the risks, signs, and symptoms of male breast cancer, and genetic consultation for males at increased risk and for their family members; and (5) supports Medicare and insurance coverage for male breast cancer surveillance and diagnostic methods, including clinical breast examination, mammography, genetic consultation, and genetic testing, when indicated. CSAPH Rep. 2, A-09; Reaffirmed: CSAPH Rep. 01, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 133
(November 2020)

Introduced by: Haidn Foster, University of Cincinnati College of Medicine; Leanna Knight, Davy Ran, University of Rochester School of Medicine and Dentistry; Puja Mohan, Northeast Ohio Medical University

Sponsored by: N/A

Subject: Study of Health Disparities Accreditation Criteria in Undergraduate Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Our AMA supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum (H-295.874); and

Whereas, Our AMA additionally supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students (H-295.874); and

Whereas, The Society of General Internal Medicine Health Disparities Task Force has developed specific recommendations and guidelines for curricula focusing on health disparities, including helping medical students to develop a commitment to eliminating inequities in health care quality by understanding and assuming their professional role in addressing this pressing health care crisis[1]; and

Whereas, The Liaison Committee on Medical Education (LCME) is tasked with accrediting America's allopathic medical schools; and

Whereas, The LCME is jointly sponsored by our AMA and the Association of American Medical Colleges (AAMC); and

Whereas, LCME accreditation criterion 7.6, Cultural Competence and Health Care Disparities, requires medical schools to provide instruction regarding the recognition of the impact of disparities in health care on medically underserved populations and potential solutions to eliminate health care disparities[2]; and

Whereas, Some have criticized the current state of American undergraduate medical education surrounding social determinants of health and health disparities as focusing too much on the existence of disparities without deeply interrogating how those disparities may be mitigated by today's medical students[3]; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to study effective means of teaching medical students a variety of possible solutions to health disparities as well as ways of

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effectively evaluating undergraduate medical curricula on this topic and report its findings to the Association of American Medical Colleges and the Liaison Committee on Medical Education.

Fiscal Note: TBD

Date Received: 08/01/2020

References:

1. Smith W, Betancourt J, Wynia M et al. Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care. *Ann Intern Med*. 2007;147(9):654. doi:10.7326/0003-4819-147-9-200711060-00010
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RELEVANT AMA AND AMA-MSS POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.
CME Rep. 11, A-06 Reaffirmation A-11 Modified in lieu of Res. 908, I-14 Reaffirmed in lieu of Res. 306, A-15 Reaffirmed: BOT Rep. 39, A-18

Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum 295.181MSS

AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H295.874]) (Reaffirmed: MSS GC Rep A, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 134
(November 2020)

Introduced by: Haidn Foster, University of Cincinnati College of Medicine; Leanna Knight, Davy Ran, University of Rochester School of Medicine and Dentistry

Sponsored by: N/A

Subject: Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Of indebted medical students, the average educational debt of the class of 2019 was $201,490[1]; and

Whereas, AMA Interim and Annual conferences do not have registration fees, thereby decreasing financial barriers for medical student members to participate in AMA business; and

Whereas, Some medical student members of the AMA who hold certain official roles receive reimbursement for their travel and incidental costs to attend AMA Interim and Annual conferences—either by the AMA or by sponsoring organizations such as state medical societies; and

Whereas, Some medical students receive school funding to attend AMA conferences, often from a limited school-wide fund intended to defray the costs of presenting research; and

Whereas, Despite these measures, travel, food, and other incidental costs to attend AMA conferences are prohibitive for many medical students who do not receive external funding; and

Whereas, Our AMA is dedicated to the professional development of student, resident and fellow, and young physician section representatives (G-600.030); therefore be it

RESOLVED, That our AMA-MSS study the feasibility and efficacy of an AMA-administered need-based scholarship program to defray the costs of medical student attendance at AMA national meetings and report its findings to the AMA-MSS at the next AMA-MSS national meeting.

Fiscal Note: TBD

Date Received: 08/01/2020

References:

1. AAMC. *Medical Student Education: Debt, Costs, And Loan Repayment Fact Card*. AAMC; 2019. https://store.aamc.org/downloadable/download/sample/sample_id/296/. Accessed March 16, 2020.

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RELEVANT AMA AND AMA-MSS POLICY

Diversity of AMA Delegations G-600.030
Our AMA encourages: (1) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (2) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (5) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.
CCB/CLRPD Rep. 3, A-12

Medical Student Participation in Professional Organizations 530.024MSS
AMA-MSS will ask the AMA to work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 135
(November 2020)

Introduced by: Fatima Khan, University of Miami Miller School of Medicine

Sponsored by: Region 4

Subject: Regulation of Phthalates in Adult Personal Sexual Products

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Phthalates, particularly di-(2-ethylhexyl) phthalate (DEHP), are industrial esters used to increase the flexibility of plastic, and are recognized as endocrine disrupting to children's toys and cosmetic products by the United States Consumer Product Safety Commission[1,2]; and

Whereas, The adult sexual product industry, which includes products that include but are not limited to vibrators, dildos, strap-ons, collision aids, anal plugs, barriers, and personal lubricants, utilizes phthalates, especially DEHP, in manufacturing[3]; and

Whereas, Current research on the use of adult personal sexual products in the U.S. is limited and not meaningfully updated since a 2009 survey which reported that among adult Americans, approximately 45-53% utilized a personal sex product[4,5]; and

Whereas, A recent Canadian study surveying participants between the ages of 18-81 across a variety of ethnic backgrounds showed the prevalence of sex toy use to be 52.3%[6]; and

Whereas, A study in the Netherlands determined that approximately 87.5% of adult sexual products contain phthalates and subsequently banned their use in the production of these products[7]; and

Whereas, The presence of DEHP metabolites in women is associated with infertility, decreased oocyte yield, and pregnancy loss in certain populations, and in men is associated with increased DNA damage of spermatozoa[8-10]; and

Whereas, DEHP metabolites can cross the placental barrier, are found in breast milk, and are associated with increased insulin resistance and obesity[11]; and

Whereas, The manufacturing of adult sexual products is not currently regulated by any governing body in the United States[12]; and

Whereas, The U.S. has not conducted any risk assessments to date analyzing the exposure to phthalates from adult personal sexual products; and

Whereas, Current AMA policy already supports the regulation of all harmful endocrine disrupting chemicals through a centralized office (H-135.920) encourages that hospitals

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and physicians reduce their use of DEHP containing medical device products (H135.945), yet adult personal sexual products are not recognized in either of these resolutions because their specific risks have not been assessed; and

Whereas, the AMA has supported an increased commitment to helping patients maintain their sexual health and well being (H-295.879), but has not addressed personal sexual product use in this population; therefore be it

RESOLVED, That our AMA (1) advocates for the centralized regulation of phthalates, particularly DEHP, in adult personal sexual products; and (2) encourages the federal government to conduct a risk assessment of adult personal sexual products as a source of phthalates; and (3) supports manufacturer development of safe alternative products that do not contain phthalates.

Fiscal Note: TBD

Date Received: 09/20/2020

References:

1. Children's Products, Children's Toys, and Child Care Articles: Determinations Regarding Lead, ASTM F963 Elements, and Phthalates for Engineered Wood Products. U.S. Consumer Product Safety Commission. 2018.

2. Lioy, P.J., et al. Assessment of phthalates/phthalate alternatives in children's toys and childcare articles: Review of the report including conclusions and recommendation of the Chronic Hazard Advisory Panel of the Consumer Product Safety Commission. J Expo Sci Environ Epidemiol. 2015:25(4): 343-53.

3. Houston, L. Sex Toys. The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies. 2016:1–3.

4. Herbenick, D., et al. Prevalence and characteristics of vibrator use by women in the United States: results from a nationally representative study. J Sex Med. 2009:(7):1857-66.

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7. Biesanz, Z. Dildos, artificial vaginas, and phthalates: how toxic sex toys illustrate a broader problem for consumer protection. Law & Ineq. 2007:25(1):203-26.

8. Benjamin, S., et al. Phthalates impact human health: Epidemiological evidences and plausible mechanism of action. J Hazard Mater. 2017:340: 360-383.

9. Machtinger, R., et al. Urinary concentrations of biomarkers of phthalates and phthalate alternatives and IVF outcomes. Environ Int. 2018:111: 23-31.

10. Wang, Y., H. Zhu, and K. Kannan. A Review of Biomonitoring of Phthalate Exposures. Toxics. 2019:7(2).

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11. Ernst, J., et al. The endocrine disruptor DEHP and the ECS: analysis of a possible crosstalk. Endocr Connect. 2020:9(2):101-110.

12. Lioy PJ, Gennings C, Hauser R, Koch HM, Kortenkamp A. Changing trends in phthalate exposures. Environ Health Perspect. 2014:122(10):A264.

RELEVANT AMA AND AMA-MSS POLICY

H-135.945: Encouraging Alternatives to PVC/DEHP Products in Health.
Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP. (Res. 502, A-06. Reaffirmed: CSAPH Rep. 01, A-16).

H-295.879: Improving Sexual History Curriculum in the Medical School.
Our AMA: (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being. (Res 314, A-05. Modified: CME Rep. 01, A-15).

H-135.920: Regulation of Endocrine Disrupting Chemicals.
Our AMA will work with the federal government to pursue the following tenets: (1) regulatory oversight of endocrine disrupting chemicals should be centralized such that regulations pass through a single office to ensure coordination among agencies, with the exception of pharmaceutical agents that are regulated by the Food and Drug Administration and are used for medical purposes; (2) policy should be based on comprehensive data covering both low-level and high-level exposures; and (3) policy should be developed and revised under the direction of a collaborative group comprising endocrinologists, toxicologists, occupational/environmental medicine specialists, epidemiologists, and policymakers.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 136
(November 2020)

Introduced by: Alexandria Wellman, Matthew Riley, Southern Illinois University School of Medicine; Tariq Issa, Northwestern University Feinberg School of Medicine

Sponsored by: Association of Native American Medical Students

Subject: Increasing surgical specialty providers and anesthesiologists within rural areas

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

Whereas, Surgical deserts are a cause for concern for patients in need of emergent surgical and anesthesia care[1]; and

Whereas, Twenty-five million people in the United States do not have a plastic surgeon in their region, as plastic surgeons are disproportionately distributed in urban areas, negatively impacting rural populations[2]; and

Whereas, Over 50% of all patients transferred to Level 1 trauma centers are a result of a lack of on-call specialist coverage at the referring hospital[3]; and

Whereas, Referring patients from community hospitals without surgical specialists to tertiary academic centers can result in a delay of care for acute problems, leading to increased morbidity for those patients[4]; and

Whereas, Gaining or losing even one physician in an area can lead to changes in healthcare outcomes for that region[2]; and

Whereas, Issues with on-call specialist coverage can lead to significant implications for institutions and healthcare providers, both clinically and financially[4]; and

Whereas, Surgical specialty providers are often dis-incentivised from taking call due to difficulty in being paid for procedures performed during call periods, as over $4 billion annually is lost due to treating EMBALTA cases, due to many patients utilizing emergency departments being under- or uninsured[4]; and

Whereas, Providers who elect to take call often have increased insurance premiums due to the increased legal liability of the procedures performed during call periods[4]; and

Whereas, The satisfaction of a physician's family with the location in which they practice is a major contributing factor for physicians practicing in rural locations[5]; and

Whereas, Operating room activity is the major contributing factor to the margin of any hospital, academic or community[6]; and

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Whereas, Providing support and incentives to recruit and maintain certain surgical subspecialties, such as neurosurgery, cardiac surgery, and gastrointestinal surgery, to perform their procedures at the hospital is financially beneficial to the hospital[6]; and

Whereas, The National Health Service Corps only lists family medicine, general internal medicine, general pediatrics, obstetrics and gynecology, and geriatrics as being eligible for applying for loan reimbursement through their program[7]; therefore be it

RESOLVED, That our AMA advocate for support mechanisms and incentives for surgeons and anesthesiologists practicing in rural areas, as well as their families such as assisting in job placement for their partners and compensating moving expenses, in order to retain these needed healthcare services in rural areas; and be it further

RESOLVED, That our AMA advocate for the expansion of the National Health Service Corps to include all medical specialties, including surgery, surgical subspecialties, and anesthesiology; and be it further

RESOLVED, That our AMA support financial incentives, such as increased re-reimbursement rates for both private insurance, Medicare, and Medicaid and financial compensation at competitive rates from the hospital to the providers for procedures done on patients during on-call hours; and be it further

RESOLVED, That the following AMA policy be amended in order to better specify the need for rural surgeons and anesthesiologists in the care of farm-related injuries, Farm-Related Injuries H-10.984:

> **Farm-Related Injuries, H-10.984**
> Our AMA:
>
> (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;
>
> (2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel<u>, including trained surgical subspecialists and anesthesiologists capable of providing immediate care for injuries such as limb and digit reattachment,</u> and emergency care facilities <u>such as fully-equipped operating rooms</u> capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;
>
> (3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;
>
> (4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.

Fiscal Note: TBD

Date Received: 09/20/2020

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3. Anthony JR, Poole VN, Sexton KW, et al. Tennessee emergency hand care distributions and disparities: Emergent hand care disparities. *Hand N Y N*. 2013;8(2):172-178. doi:10.1007/s11552-013-9503-z
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7. NHSC Loan Repayment Program. HRSA National Health Service Corps. https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.html. Published June 12, 2020. Accessed September 21, 2020.

RELEVANT AMA AND AMA-MSS POLICY

Farm-Related Injuries H-10.984

Our AMA:

(1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;

(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and

other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;

(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;

(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. BOT Rep. U, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future ruralphysicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

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H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages. CME Rep. C, I-90Reaffirmation A-00Reaffirmation A-01Reaffirmation I-01Reaffirmed: CME Rep. 1, I-08Reaffirmed: CEJA Rep. 06, A-18Appended: Res. 956, I-18Appended: Res. 318, A-19

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. Sub. Res. 72, I-88

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Rural Community Health Networks H-465.980

AMA policy is that development of rural community health networks be organized using the following principles:

(1) Local delivery systems should be organized around the physical, mental and social needs of the community;

(2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management;

(3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined;

(4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and

(5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. Sub. Res. 721, I-97

Rural Health H-465.989

It is the policy of the AMA that:

(1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact;

(2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners;

(3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and

(4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants. CMS Rep. K, A-90

Rural Health H-465.986

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1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well.

2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics, and transmit the result of such evaluation to their members.

3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. CMS Rep. A, A-91

Rural Health H-465.982

The AMA:
(1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations;

(2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and

(3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas. CMS Rep. H, A-93

Economic Viability of Rural Sole Community Hospitals H-465.979

Our AMA:

(1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and

(2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy. CMS Rep. 3, A-15

Access to and Quality of Rural Health Care H-465.997

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. CMS Rep. G, A-87

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Access to Physician Services in Rural Health Clinics H-465.984

Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. Sub. Res. 717, I-91

Primary Care Physicians in Underserved Areas H-200.972

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.

(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.

(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.

(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.

(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas. CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19

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. 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

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Appended: Res. 922, I-13 Modified: CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16
Appended: Res. 323, A-19

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON BIOETHICS AND HUMANITIES

MSS CBH Report A
(November 2020)

Introduced by: MSS Committee on Bioethics and Humanities

Subject: Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Annual meeting, Resolution 38 was introduced and the following resolve clause was referred for report:

> RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of drug overdoses.

Testimony heard at the A-19 Assembly was mixed. The Reference Committee found the resolve to be novel and recommended it for adoption. Those in support of this resolution argue that current media practices add to the negative stigma surrounding drug overdoses and can negatively impact the lives of those who have had a drug overdose. Those opposed argue that the references cited tend to be anecdotal and ask CBH to conduct further research to strengthen the argument with peer reviewed materials.

While the original resolve clause references a broad terminology of “drug overdoses”, this report will focus specifically on *opioid* overdoses and the opioid epidemic. This is to address concerns regarding anecdotal references cited in the original resolution, as most of the peer-reviewed literature focuses on the media’s portrayal of opioid use disorder (OUD). Using this altered terminology and foundation, this report will support the following arguments of the original resolution: 1) peer-reviewed evidence shows that current trends in media portrayal of opioid overdoses negatively impact public opinion and increase stigma, and 2) the resolve is within the scope of the AMA.

BACKGROUND

Opioid over prescription and overdose have been focal points of US healthcare effort and attention as the number of opioid-related overdose deaths have been steadily increasing - between 1999 and 2015, the number of opioid-related overdose deaths have quadrupled and in 2017 alone, there were 47,600 overdose deaths involving opioids, comprising 67.8% of all drug overdose-related deaths that year[1,2].

Throughout this epidemic, the media has played an important role. In general, the media has the capacity to condition people’s perceptions of and attitudes towards disease severity[3]. Media and communication theory agree that media does indeed have the ability to influence audiences

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- it may set an agenda, frame issues via selective coverage and indirectly shape community attitudes and alter political decision making[4].

Agenda setting refers to the inclusion or exclusion of material to define public interest[4]. While the media may not directly tell audiences what to think, it can often tell audiences what to think *about* via selection of what information relayed[4]. For example, the *Herald Sun* Newspaper in Australia effectively put heroin at the forefront of the public agenda by consistently highlighting heroin-related overdose deaths[4]. In the United States in particular, from 1998-2012, the news media largely focused on criminal justice solutions for the opioid epidemic, whereas from 2013-2017 there was a shift to treatment, harm reduction, and prevention solutions[5]. Several evidence-based solutions were rarely covered - medication treatment was mentioned in only 9% of news stories while syringe service programs and safe injection sites were mentioned in only 5% and 2% of stories[5].

In addition to agenda setting, there is the issue of framing, in which the media may select aspects of a “perceived reality” and make them more salient in order to promote a specific interpretation or moral evaluation[4]. An example is how the media portrays opioid addiction in the context of race, which depicts a relationship that distinguishes “white from black (and brown) suffering, white from black culpability, and white from black deservingness[6]. Language specifically can also be used to frame issues and create social norms[7]. Coded language, for example, typically depicts “urban” as code for black or Latino, while “suburban”/“rural” is used to code for white, effectively creating perceived separate spaces for white and black drug users[6].

Language use can also create stigma, defined as a process in which people with a specific social identity are labeled, stereotyped and devalued[7]. In the United States between 2008 and 2018, news reports covering addiction used stigmatizing language such as “substance abuser” and “addict” in 49% of stories, whereas only 2% used less stigmatizing substitutes such as “person with a substance use disorder”. In addition, the years from 2008 to 2009 saw a sharp increase in the amount of stigmatizing language - from 37% to 45%[5]. This stigmatizing language can be used to frame social situations, which enforces the notion that these [opioid use disorders or overdoses] are moral failures and places shame on the affected individual[8]. For example, when the story is about “urban” (black) communities for example, media stories use stigmatizing terms like “addict” and drug activity and convey a sense of normalcy for these communities. However, when the story is about “suburban” (white) communities, drug activity is portrayed as shocking or out of the ordinary[6], and white people are portrayed as victims of an epidemic[9].

This difference in framing leads to a system where Black and Brown people who use drugs are more likely to be incarcerated and less likely to be offered access to healthcare providers, addiction treatment, and tools to prevent overdose and infection[6]. The U.S Surgeon General has also acknowledged the impact of stigma and the barriers it creates to individuals wishing to seek treatment, as nearly 25% of individuals report negative impact on their job or fear of a negative opinion of community members as a reason for not seeking treatment [8]. Stigma also affects opioid-related policies by its influence on the public at large: higher levels of stigma are associated with greater support for punitive policies instead of investment in prevention and treatment programs[11]. Notably, ecological studies have shown a significant tendency for increases in fatal overdoses to follow increased media coverage of opioid-related deaths[10].

DISCUSSION

During the proceedings of the 2019 Annual meeting, some voiced concern that such a resolution would equate to the AMA dictating how media organizations conduct their business, or result in the CDC enforcing standards of conduct. The members of this committee do not

share this concern. As the resolution is written, the CDC and others would develop guidelines regarding opioid coverage in the news media, but would stop short of compelling any organizations to fall in line with those recommendations. This resolution seeks to foster more appropriate media coverage, not dictate the editorial process.

Further, the resolve clause in this resolution is similar to AMA policy H-145.971 which "encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings…" The concept of encouraging more thoughtful public engagement with health-related issues is not new to the AMA and fits well within our mission.

This report has also demonstrated an abundance of peer-reviewed evidence that outlines the impact that media messaging has on public health. While these practices lead to deleterious representations of the complexity of addiction and treatment, responsible media coverage has the capacity to reduce stigma and break cycles of misinformation[3].

Lastly, our committee found that most of the peer-reviewed evidence in this report focused specifically on opioid overdoses. To address the concerns regarding anecdotal evidence, we therefore recommend that the authors change the language in their title and resolved clause to be more specific by replacing "drug overdoses" with "opioid overdoses."

RECOMMENDATIONS

Your Committee on Bioethics and Humanities recommends that the following recommendation be adopted and the remainder of this report is filed:

> TITLE: Development and Implementation of Recommendations for Responsible Media Coverage of Opioid ~~Drug~~ Overdoses
>
> RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of Opioid ~~Drug~~ overdoses.

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Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971:

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for **media** coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND MINORITY ISSUES COMMITTEE

MSS CEQM MIC Report A
(November 2020)

Introduced by: MSS Committee on Economics and Quality in Medicine and Minority Issues Committee

Subject: Laying the first steps towards a transition to a financial and citizenship need-blind model for organ procurement and transplantation

Referred by: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Annual meeting, MSS Resolution 46 asked the AMA to support and advocate for federal laws removing financial barriers to transplant recipients, to create a national taskforce for organ procurement that would be renewed every 20 years, to research a fiscal federal strategy that would cover annual transplant costs, and to make amendments to 6.2.1. in the Code of Ethics and AMA existing policy H-370.982 that would alter statements to not regard immigration status. The A-19 Reference Committee referred MSS Resolution 46 for report.

The MSS Assembly and Reference Committee specifically stated concerns over:

1) including criteria for having established a “physical presence” in the United States
2) the resource intensive nature and feasibility of advocating and creating such a taskforce
3) the limited feasibility of the AMA researching a fiscal federal strategy to cover annual transplantation costs given the AMA is not a body that commonly conducts such research
4) the fact that the HOD cannot amend the AMA Ethical Opinion, and would have to be referred to the Council on Ethical and Judicial Affairs (CEJA)

Both the Reference Committee and Assembly agreed that this is an important resolution that could be strengthened through an assigned report. This report aims to address the potential fiscal and political capital that would come of the asks.

BACKGROUND

Of the 11 million undocumented immigrants residing within the United States, an estimated 6,500 have end-stage renal disease (ESRD) requiring chronic dialysis[1]. Many of these patients, however, are unable to access appropriate care, largely due to financial barriers. The average cost of chronic hemodialysis per patient is $90,000/year. Most patients with ESRD who are citizens are able to afford this through the 1972 Public Law 92–603 amendment to the Social Security Act, which provides financial coverage to those who qualify for Social Security benefits[2,3].Unfortunately, undocumented immigrants are excluded from these benefits and must rely on emergent-only hemodialysis, and only after they develop life-threatening metabolic disturbances[4]. The annual costs of these treatments range from $285,000 to $400,000 per

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patient[5]. Undocumented immigrants are able to receive emergent hemodialysis because the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all states must provide federally funded emergency medical treatment. However, no federal, state, or local funds – including Medicaid, Medicare, and the Children's Health Insurance Program - are available for maintenance therapy for undocumented immigrants with ESRD, as dictated by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act[6,14,16].

The alternative treatment option for ESRD is kidney transplantation. Not only is this approach curative, it also has lower associated annual costs, averaging $39,939 per patient for HLA compatible living donor transplantation[7,8,17]. Current ethical and legal guidelines dictate that medical need alone should determine how organs are allocated for transplant. However, only 1% of all kidney transplant recipients per year are non-citizens, which is out of proportion to the 2-3% annual contribution to the donor organ pool made by this same population[9]. While organs may be allocated to undocumented immigrants, current policy excludes this patient population from receiving federal, state, and local funding to cover their transplantation and post-transplantation care[10,11,14,20]. This means that undocumented persons are not only unable to afford these potentially curative transplants, they are also unable to pay for costly post-transplant immunosuppressive medications, leading to graft failure over time. Consequently, thousands of patients with ESRD are forced to go without a potentially lifesaving transplant simply because of their legal status. These patients continue to receive costly dialysis treatment paid for by state emergency health care funds. It is evident, therefore, that there exists a disparity in access to adequate long-term treatment options for undocumented persons with ESRD. Not only is there a moral imperative to advocate for the improved health outcomes of these persons, there is a financial benefit to improving access to kidney transplants. Since kidney transplantation is a curative and cost-effective long-term treatment option for ESRD, efforts should be made to facilitate access for undocumented persons.

While kidney transplantation is the most common organ transplant procedure,[21] the lack of access to organs is even more complicated for other kinds of transplant since there are fewer non-surgical treatment options6. A recent study of liver transplant indicates that undocumented persons rarely get access to liver transplantation, and when they do, these patients are sicker, indicating a longer wait22,23. Undocumented persons' access to organ transplantation is further complicated by location. Access to transplantation varies by state, with almost a quarter of all liver transplants occurring at two transplant centers in California[22], [23]. Each transplant center gets to set their own rules for who can be added to the waiting list for an organ[24]. These rules, while also considering the patient's health and risk factors for transplant, also consider financial status, and without insurance, an undocumented patient is less likely to be considered a good candidate and is therefore less likely to get access to a organ transplant[25].
As the biggest barrier to organ transplantation in this population remains financial in nature, it is important to continue research into feasible fiscal federal strategies that would cover annual transplant costs for undocumented and uninsured patients.

DISCUSSION

Organ procurement is an issue that affects over 100,000 people each year, and it is important to work towards equal access for all patients. Not only is there a moral imperative to advocate for the improved health outcomes of these persons, there is a financial benefit to improving access to kidney transplants. Since kidney transplantation is a curative and cost-effective long-term treatment option for ESRD, efforts should be made to facilitate access for undocumented persons.

In regards to the first resolved clause of MSS Resolution 46, while the spirit of the clause is

certainly in the interest of ensuring equality for organ transplant recipients, the phrase “physical presence in the U.S. prior to needing the organ” is vague and raises questions about what “physical presence” means and how it is confirmed. While the intention of ensuring that non citizens are not excluded from this process is clear and in line with previous AMA policy, such as H-370.990, there is concern that by keeping this phrase vague, “physical presence” is left open to interpretation and could possibly work against the overall goal of equal access. This phrase is repeated in resolved clause 4. In addition, in resolved clause 5, the language is not consistent with previous clauses, using the wording “as long as the person lives in the U.S.” and for clarity, having the same language here as was used in previous resolved clauses would be helpful. Overall, in order to ensure that non-citizens are considered viable recipients for organ transplants, the language needs more specificity.

In regards to the second resolved clause, the intention of keeping policies regarding organ procurement up to date is reasonable given our changing demographics and technologies. However, the choice to renew the task force every 20 years is not backed by any evidence or reasoning. A suggestion for specification is asking for a renewal every ten years since the national census is done every ten years, and this will provide standardized updates on demographic information, characteristics of minority populations, and immigration trends that can be considered accordingly by the task force. However, it is important to note that the AMA would not be the optimal body to establish this task force given the organization’s structure, but would be better off to support the establishment of this task force.

Similarly, regarding resolved clause 3, the AMA is not a body that routinely conducts primary research, and would be more equipped to support researching a federal fiscal strategy to cover the costs of organ transplantation and coverage of follow up care, including office visits and immunosuppressants.

Although the spirit and intention of fourth resolved clause is in line with current AMA policy, it is similarly out of scope, as changes to the Code of Ethics must be referred to the Council of Ethical and Judicial Affairs. In addition, it would be redundant to the asks of the fifth resolved clause.

The Minority Issues Committee did consider the suggested amendment by addition to the Code of Ethics 6.2.1 to be appropriate for an amendment by addition in H.370.982 in resolved clause 5. As written, this amendment strengthens the current policy, clarifying that a citizenship blind approach to organ transplantation is ethical in accordance to legal precedent. On the other hand, we believe that attempts to clarify the physical presence of an individual in the US may work against the goal of the resolution as previously stated.

It is within the scope of the AMA and the AMA-MSS to support the removal of financial barriers to access organ transplantation as:

1) It improves equitable access to a benefit to a marginalized population to reduce health disparities, where the major hurdle to receiving a transplanted is financial cost.
2) Health care costs associated with emergent dialysis far outweigh the costs associated with routine hemodialysis and organ transplantation

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

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1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured and underinsured regardless of United States Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and

2) That the second resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA ~~promote and advocate~~ support the creation for of a 2020 national taskforce for organ procurement and transplant, that will be renewed every ~~20~~ 10 years to ~~access~~ assess the needs of the generation and account for changes in demographics and technology; and

3) That the third resolved clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a fiscal federal strategy to cover annual transplant costs in the U.S. for patients without or are ineligible for insurance distributed among the over 200 transplant centers in the U.S.; and

4) That the fifth resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS).

5) That the fourth resolved be not adopted.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM Report A
(November 2020)

Introduced by: MSS Committee on Economics and Quality in Medicine

Subject: Promoting Early Access to Diabetes Care to Reduce ESRD

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, Resolution 12, Promoting Early Access to Diabetes Care to Reduce ESRD was introduced and referred to the Committee on Economics & Quality in Medicine for further study. The resolution, "RESOLVED, That our AMA shall call upon Congress for the expansion of Medicare Part D to individuals less than 65 years of age with diabetes for the procurement of all varieties of insulin, blood glucose monitoring supplies, and non-insulin antihyperglycemic treatment with the intention of reducing the incidence of End Stage Renal Disease." While many delegates were advocates of the spirit of the resolution, concerns regarding payment and feasibility of such a resolution ultimately ended with the resolution being referred for study.

BACKGROUND

The *Social Security Amendments of 1972* expanded Medicare coverage to individuals under the age of 65 with End Stage Renal Disease (ESRD).[1] The legislation allowed for individuals (and/or the spouses/dependents of individuals) insured under social security with ESRD to receive Medicare coverage for life-preserving dialysis treatment or transplantation. The expansion was largely proposed due to the lack of insurance coverage for chronic dialysis treatment at the time. The ESRD provisions (Section 299I of the *Social Security Amendments of 1972*) were accepted and passed under obscure circumstances involving a presidential election, an eleventh-hour amendment, unconventional citizen testimony, unanticipated public response, political gamesmanship, and the anticipation that the country would soon adopt universal health care. The ESRD coverage program ultimately took effect in July 1973. The initial cost estimates for the program were based on a sole individual's testimony and ultimately were found to be a severe underestimate. Today, there is a need to adjust this legislation and address the cost-ineffectiveness of treating ESRD under the current plan. In 2016, Medicare spent $35 billion on individuals with ESRD.[2] Fewer than 1% of Medicare beneficiaries have ESRD; however, they account for over 7% of Medicare fee-for-service spending.[3] Since the original legislation took effect, the number of patients receiving chronic dialysis has increased from 10,000 to over 500,000. [2] Although, the United States consistently ranks as having one of the highest standardized rates of ESRD in the world, the incidence of ESRD appears to be on the decline.[3,4] It has been suggested that this is due to improved treatment, prevention and postponement of kidney failure.[3] While ESRD is nearly universally covered by Medicare, roughly 10% of adults with non-dialysis dependent chronic kidney disease are uninsured, and some percentage of those with insurance are underinsured.[4] The uninsured rate is estimated to be higher for those

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with early stage kidney disease compared to those with late stage kidney disease. The cost/person for treating individuals with non-dialysis dependent chronic kidney diseases increases significantly as the disease progresses from Stage 3 to Stage 4 and 5. Although the cost/person for Stage 3 treatment is comparable to that of Stage 1 and 2, the highest economic burden currently comes from treating patients with stage 3 kidney disease because it is the most prevalent stage in the U.S.

This resolution addresses access to antihyperglycemic agents and demonstrates the potential to reduce the incidence of ESRD through subsequent improved glycemic control. In regard to access, the expansion of Medicare Part D to diabetic individuals under 65 years of age for the procurement of all varieties of insulin, blood glucose monitoring supplies, and non-insulin antihyperglycemic treatment would reduce the overall cost burden of treatment for patients. These effects would be especially evident in certain vulnerable populations, such as the uninsured. The expansion of healthcare coverage would be consistent with AMA's goals of improving access to care, access to medications, and controlling costs for consumers. It is unclear if the lack of Part D-level insurance coverage in this population is contributing to the incidence of diabetic ESRD, and if so, to what extent it is. However, if this is the case, reducing the incidence of ESRD through improved glycemic control would be consistent with AMA's broader goals.

Unfortunately, the administrative implications of this change seem rather complex. The main question to be answered is how this change will impact the current insurance plans for individuals who qualify for the extended Medicare Part D Coverage. In specific, how would this change apply to those who have private insurance plans or those who are uninsured?

Prescription drug coverage is an essential health benefit under the ACA. Thus, all private plans, as well as Medicaid, already provide prescription drug coverage. Providing Medicare Part D coverage to these patients, just for insulin and antihyperglycemic agents, would be extremely complicated when determining how it factors into the copay/deductible/maximum limits of their existing prescription drug coverage. The question to be answered is whether patients would have a decision in the matter. For example, could patients choose to use their private insurance instead of Medicare Part D to pay for these medications? How would this impact health insurance premiums? In addition, it is important to consider those who are uninsured. Although it is commendable to have government-guaranteed prescription drug coverage for a certain class of drugs for uninsured Americans, is it ethically acceptable to do so without providing coverage for everything else?

The other questions that need to be answered are related to the structure of Medicare. Currently, Medicare Part D can be used with other insurance programs when patients are eligible for Part D. However, there is no precedent for having dual coverage for certain classes of drugs but not others. New Medicare Part D drug plans covering only antihyperglycemics would have to be offered by private insurers and approved by CMS. Despite some predictable hurdles, this may be feasible through partnerships with private insurers. The bigger question then becomes whether it is appropriate to limit this expansion to only one disease/drug class. There are other conditions for which inadequate prevention ends up costing Medicare a significant amount of money. For example, hypercholesterolemia leads to chronic conditions which are of significant cost to Medicare, should we also expand coverage to include statins? Although the spirit of this resolution is commendable, there are questions regarding the feasibility of this solution.

DISCUSSION

The prevalence of ESRD in the United States has increased nearly three-fold over the past 30 years, driven largely by the rising prevalence of diabetes, the leading cause of ESRD. Our AMA has already shown support for the goal of reducing the financial burden posed by diabetes management, through policies aimed at expanding coverage of glucose-monitoring devices and improving diabetes education, research, and prevention.

This resolution proposes expanding Medicare Part D to individuals under age 65 with diabetes for the procurement of insulin, antihyperglycemic medications, and blood glucose monitoring equipment, in order to reduce the incidence of ESRD. While the spirit of the resolution is consistent with existing AMA policy, CEQM fears that the proposed policy would not be effective at achieving its stated goal, and could have the unintended effect of causing worse health outcomes for individuals with diabetes.

The authors aim to improve the affordability of insulin and antihyperglycemic drugs by expanding the Medicare Part D benefit to beneficiaries with diabetes under age 65. Expanding insurance coverage could help achieve this goal, but the authors do not make the case that Medicare Part D would be an appropriate system for expanding coverage, compared to other forms of insurance (e.g., employer-sponsored insurance, marketplace insurance, or Medicaid). There are considerable shortcomings to the Part D benefit compared with other models of coverage. For example, Medicare Part D does not have an out-of-pocket spending cap. Some beneficiaries, particularly those who take high-cost specialty pharmaceuticals, face massive out-of-pocket spending under Medicare Part D. In contrast, employer-sponsored insurance has an out-of-pocket cap, as mandated under the Affordable Care Act. If the goal of the authors' resolution is to make antihyperglycemic medications more affordable, then selecting Medicare Part D as the model for delivering drug coverage does not seem to be the most effective method.

Moreover, the resolution proposes a deeply unusual tactic of expanding access to drug insurance without mandating that beneficiaries also obtain medical insurance. This approach could result in a new population of Medicare Part D beneficiaries who lack medical insurance. These individuals may find themselves in the predicament of having insurance to aid in the purchase of drugs, but may be unable to afford doctor appointments to obtain prescriptions. In addition, recommended diabetes care requires not only the use of medications, but also involves doctor appointments for foot and eye exams, and counseling surrounding lifestyle modifications, such as physical activity, dietary modifications, and smoking cessation. Enabling beneficiaries to obtain drug insurance without medical insurance may counterintuitively result in worse diabetes management.

For these reasons, CEQM recommends that MSS does not adopt Resolution 12. The spirit of the resolution is consistent with existing AMA policy, but the tactics proposed are deeply problematic and could harm beneficiaries with diabetes, rather than helping them.

CONCLUSION

The resolve clause is certainly within the scope of the AMA and consistent with the long-standing goals of the MSS and AMA to expand access to prescription drugs and improve outcomes through better preventative care. However, this particular resolution raises a number of questions as to how such a program would actually be implemented. Medicare Part D does not currently provide stand-alone age-blind coverage for any class of medications for any group of individuals, so such a proposal has never been attempted before. It is unclear how coverage

for antihyperglycemics through Medicare Part D would work with Medicaid and private health insurance, both of which currently cover prescription drugs including antihyperglycemic agents. Further, since Medicare Part D is offered through private insurance plans approved by CMS, private companies would have to develop plans specifically for the coverage of antihyperglycemics for diabetic patients under 65, and it is unclear how that would work mechanistically.

Further, the logical argument underpinning expanding Medicare Part D cover to antihyperglycemics only seems weak. The reasoning seems to be that Medicare, for specific historical reasons, covers patients of any age with ESRD, and since poorly controlled diabetes is a leading cause of ESRD, it makes sense to try to reduce the incidence of ESRD by expanding access to agents that improve glycemic control. However, many other diseases can lead to ESRD, including hypertension and polycystic kidney disease, and it is unclear why Medicare Part D coverage should not be expanded to cover prescription drugs that can treat those conditions based on the argument put forth in the resolution. Further, many diseases that can be prevented with prescription drugs taken before the age of 65 can lead to diseases that impose an economic burden on Medicare, so it is doubly unclear why Medicare Part D coverage would be restricted to antihyperglycemics.

In sum total, it seems to us that while the spirit of the resolution is very good, it seems there is a lack of precedent for such a change, major questions exist as to how this resolution would be implemented were it enacted, and the reasoning for restricting Part D coverage to antihyperglycemics is unclear.

RECOMMENDATION

Your Committee on Economics and Quality in Medicine recommends that Resolution 12 not be adopted.

References:

1. Institute of Medicine. Origins of the Medicare Kidney Disease Entitlement: The Societal Security Amendments of 1972. In: *Biomedical Politics*. Washington, DC: The National Academies Press; 1991.
2. U.S. Renal Data System. USRDS 2018 Annual Data Report: Atlas of End-Stage Renal Disease in the United States, Chapter 9: Healthcare Expenditures for Persons with ESRD. 2019;2:519-528.
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5. Medicare C for, Services M. Medicare Coverage of Kidney Dialysis & Kidney Transplant Services. *Dep Heal Hum Serv*. 2012:17-28.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM Report B
(November 2020)

Introduced by: MSS Committee on Economics and Quality in Medicine

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

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

Resolution 23 was referred to the Committee on Economics and Quality Medicine following Interim 2019. Resolution 23 recommends that our AMA encourage scientific research on the benefits of a comprehensive eye exam and the benefits of visual aids in Medicaid eligible individuals. At Interim 2019, Resolution 23 was not recommended to be adopted by the reference committee. The authors extracted the resolution during the Assembly meeting and recommended that the resolution be referred for study because there is a lack of research on why appropriate scientific bodies have not recommended comprehensive eye exams and visual aids be covered by Medicaid for eligible individuals.

Resolution 23 focuses on asking for increased research to determine the benefits of visual aids and screening for Medicaid patients. This ask differed from current AMA policy due to its focus on research and Medicaid patients as opposed to the children and the elderly, which are covered by AMA policies Encouraging Vision Screening for Schoolchildren H-425.977 and Eye Exams for the Elderly H-25.990.

Resolution 23 was referred to the Committee of Economics and Quality Medicine to discuss the potential benefits and consequences of adding comprehensive eye exams and the benefits of visual aids in adults eligible for Medicaid. The resolution reads:

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

BACKGROUND

Twelve million people 40 years of age and over in the United States have vision impairment (VI). Approximately 1 million are blind, 3 million have vision impairment after correction, and 8 million have vision impairment due to uncorrected refractive error. These numbers are only projected to increase due to the prevalence of diabetes and chronic conditions in the aging US population, lending to the long term importance of proper eye care. By 2050, the numbers are projected to double to approximately 2.01 million people who are blind, or having VI of 20/200 or worse, 6.95 million people with VI, and 16.4 million with VI due to uncorrected refractive error.

Vision impairment has lasting social, economic, and medical consequences for millions of Americans by causing disability, loss of productivity, and diminished quality of life due to the

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inability to read, write, drive safely among other daily activities. For example, the economic impact of major vision problems among the adult population 40 years and older is projected to be greater than $145 billion.

Research that has analyzed the lack of access to vision care and the benefits of visual screening in Medicaid patients has been limited. One study showed that Medicaid beneficiaries find it harder to obtain an eye care appointment compared to individuals with private health insurance and were 234% more likely not to receive any glaucoma testing after initial testing.

Currently there are no federal guidelines requiring Medicaid coverage of routine visual screening exams in adults 21 years and older with most participating states providing vision screening coverage at 24 to 48-month intervals. Thirty-three states offer optional, limited Medicaid coverage of eyeglasses and other visual aids; six states only offer these benefits to children and those with severe eye conditions.

DISCUSSION

There are numerous advantages to supporting research on visual exams for Medicaid beneficiaries. The mere size of the United States population that falls under Medicaid's jurisdiction suggests that increased research should be considered, not to mention that it is a growing segment of the population. Beyond population size, the lasting social and economic factors are important to consider. Quality of life is an important determinant of health in the United States with vision being one of the greatest factors on quality of life.[1]

Economically, the impact of vision impairment is evident and anything to lessen that is encouraged. In a study by the National Opinion Research Center (NORC) at the University of Chicago the total economic burden of eye disorders and vision loss in the United States was $139 billion. Within that number is $65 billion in direct medical costs, $48 billion in lost productivity, $20 billion in long-term care for vision loss, and other losses due to education and screenings.[2] The Centers for Disease Control (CDC) has long supported screenings for breast cancer, heart disease, etc. as a basic tool in modern public health and preventative medicine. The CDC goes on to say, "a comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective.[3] In order to attempt to decrease the costs as the growing population with eye problems, medicine has to be proactive.

In an article by the New England Journal of Medicine in 1993, Dr. James Fries advocates for a theoretical solution that medical costs can be decreased by utilizing preventative medicine and screenings.[4] This claim has been backed up by numerous health economic studies since it was published and is often taught in healthcare economics courses. The CDC estimates that up to 90% of the $3.5 trillion in annual healthcare expenditures are spent on people with chronic and mental health conditions. The CDC has also found that chronic disease is best prevented by catching the disease early, such as in heart disease and diabetes.[5]

This argument lends to the belief that the benefits of comprehensive vision screening goes beyond those that are beneficiaries of Medicaid. Increasing screening on Medicaid beneficiaries could lead to decreased spending on healthcare in the United States. Current AMA policy H-425.997 states that "the AMA encourages the development of policies and mechanisms to assure continuity, coordination, and continuous availability of patient care, including professional preventative care and early detection screening services." Studying the long-term effects of routine comprehensive eye exams and the benefits of visual aids is supported by this policy.

This potential decrease in utilization of Medicaid funds for chronic eye conditions could allow the funds to be reallocated to other areas that are currently underfunded.

As with many other chronic conditions, early detection and intervention are critical for slowing the progress of disease in ocular conditions. Being able to identify age-related macular degeneration, cataracts, or glaucoma early will allow for steps to be taken sooner that are more cost effective than acute treatment once these chronic diseases have progressed. With the aging population in the United States, the management and prevention of chronic diseases is as important as ever. The importance of supporting research to find the true value of comprehensive screening and benefits of visual aids in adults eligible for Medicaid is imperative to lowering future healthcare costs.

CONCLUSION

It is well proven that preventative health care screenings are a major factor in decreasing costs for treating future chronic conditions. Eye health follows the same principle. By having Medicaid beneficiaries receive comprehensive eye exams, Medicaid would be able to screen and identify chronic eye conditions such as macular degeneration, cataracts, and glaucoma. Early screening and treatment of these conditions may have the potential to reduce costs significantly for Medicaid later on. As a result, it is important that additional research regarding the cost effectiveness and efficacy of providing comprehensive eye exams to Medicaid recipients be done. Additional information regarding the possible benefits and consequences of Medicaid sponsored comprehensive eye exams will allow the AMA to later support the incorporation of comprehensive eye exams into Medicaid coverage with adequate research and data to be knowledgeable and credible. With this additional research, the AMA can play an important role in making sure a larger percentage of Americans have adequate vision health coverage.

RECOMMENDATIONS

Your Committee on Economics and Quality in Medicine recommends that the following recommendations be adopted and the remainder of the report filed:

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

References:

1. Langelaan M, Boer MRD, Nispen RMAV, Wouters B, Moll AC, Ger H. M. B. Van Rens. Impact of Visual Impairment on Quality of Life: A Comparison With Quality of Life in the General Population and With Other Chronic Conditions. *Ophthalmic Epidemiology*. 2007;14(3):119-126. doi:10.1080/09286580601139212.

2. The Economic Burden of Vision Loss and Eye Disorders in the United States. NORC at the University of Chicago. https://www.norc.org/Research/Projects/Pages/the-economic-burden-of-vision-loss-and-eye-disorders-in-the-united-states.aspx. Accessed March 31, 2020.

3. Keep an Eye on Your Vision Health. Centers for Disease Control and Prevention. https://www.cdc.gov/features/healthyvision/index.html. Published July 26, 2018. Accessed March 31, 2020.

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REPORT OF THE MEDICAL STUDENT SECTION COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM REPORT C
(November 2020)

Introduced by: MSS Committee on Economics and Quality in Medicine

Subject: Researching policy recommendations to address the shortfalls of Employer-Sponsored health insurance

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

In August of 2020, the Committee on Economics & Quality in Medicine (CEQM) submitted a Governing Council Action Item entitled "Researching policy recommendations to address the shortfalls of employer-sponsored health insurance." The Action Item requested that the Governing Council grant CEQM the authority to self-generate a formal report on the topic of employer-sponsored health insurance, for submission at the November 2020 Special Meeting. CEQM cited the COVID-19 Pandemic and associated job losses as an argument for the report's timeliness and importance. The goal, as described, was to research the effectiveness and ultimate appropriateness of a health system that largely relies on employer-sponsored health insurance, and make appropriate policy recommendations. The Governing Council accepted this request and granted CEQM the authority to produce this report. In this report, CEQM (the authors) focused on several key questions: How did the United States come to have such a system? What is the current state of this healthcare system? How are employers impacted by this system? How are employed and unemployed individuals impacted by this system? What are alternatives to this system? What barriers keep the US from transitioning to a different system? How effective and resilient has this employer-sponsored system been during the COVID-19 Pandemic? The authors conclude this report with policy recommendations that they believe the AMA MSS and House of Delegates should consider for MSS external policy.

BACKGROUND

History of the Current System

One of the earliest examples of an employer-sponsored health insurance system is that of Baylor University Hospital in 1929. Dallas school teachers established a prepayment system where each teacher would be able to receive up to 3 weeks of hospital care in exchange for payment of $3 a semester or $6 for the year. At the time, hospitals were not desirable places to receive care. Instead, hospitals were generally for the poor. At the time, hospitals were financially unstable due to the imbalance between charity care and paying patients. Other hospitals took notice of the financial success of Baylor University Hospital. Citywide plans similar to that of the Baylor University Hospital prepayment plan rapidly became more common. These plans would eventually evolve into Blue Cross and Blue Shield[1].

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In 1942, the U.S. involvement in World War II led to a labor shortage at home. Salaries began to rise exponentially as employers tried to attract an increasingly short supply of workers to their firms. This led to dramatic wage inflation, spurring the federal government to pass the Stabilization Act of 1942. In order to attract employees during the wage freeze, employers began to offer health insurance, among other benefits, in order to compete for skilled workers. Widespread discontent among labor unions led the War Labor Board to make employer-sponsored health insurance tax-deductible, a change which proved too popular to remove after the war[2,3]. These early decisions played a major role in shaping the American healthcare system's early growth. Cracks quickly began to show as those who retired lost access to their employer's insurance and thus found themselves without any affordable options for insurance, directly leading to the creation of Medicare and Medicaid in 1965. After these major reforms were instituted, comprehensive healthcare reform proved politically untenable until the passage of the Patient Protection and Affordable Care Act in 2010, which dramatically expanded Medicaid, banned discrimination against patients with pre-existing conditions, and established state-run healthcare exchanges where consumers could purchase health insurance directly from private insurers. However, the exchanges were not designed to replace employer-sponsored health insurance as the major source of insurance. In fact, the Affordable Care Act mandates that all businesses with 50 or more full-time employees must provide insurance benefits[4]. Despite these substantial changes, employer-sponsored insurance is still the backbone of the payment system and the negative consequences of its haphazard and unintentional development have once again returned to the spotlight.

Macro Effects of the Current System

Today, the United States' current employer-sponsored health insurance system is associated with significant costs that are directly borne by consumers through insurance premiums. Tying employment to insurance significantly limits the choices available to employees, and in so doing, prevents employees from participating in a true, population-level market for insurance[5]. Thus, the American system fails to achieve both the economies of scale available to countries with consolidated, centralized public insurance systems *and* the savings and efficiencies associated with market competition. Additionally, because America's health insurance system is significantly more fragmented than other countries, with individual companies either negotiating group plans for their employees with insurers or insuring their own employees directly, administrative costs represent a much larger proportion of healthcare spending than in other comparable industrialized nations[3]. Private health insurance companies spend between 12-13% of their total health expenditures on administrative overhead annually, a proportion 5-10x higher than the amount paid by Medicare and comparable Organisation for Economic Co-operation and Development **(**OECD) countries which represent single-payer, multiplayer, and all-private insurance systems[6,7,8,9]. These expenditures amount to approximately $300 billion in administrative outlays per annum, which would be reduced by over $200 billion per annum if private plans' administrative costs more closely matched those of Medicare[6,7,10]. Similar savings would be achieved if the administrative costs of private programs in the US more closely approximated those of private programs offered in other peer nations like Germany or the Netherlands[8,11]. The relatively high cost of health insurance administration does not appear to be shared by private programs internationally, but rather is a unique feature of American private insurance programs. Further, administrative costs are one of the largest contributors to the significantly higher per capita healthcare costs borne by the American public compared to other industrialized countries, alongside labor costs and the prices of goods and services[11,12]. Finally, the inherently fragmented nature of America's employer-sponsored insurance system directly contributes to the exorbitant administrative costs paid by insurance providers, as a lack of bureaucratic standardization and opaque, individualized hospital-to-insurance provider

negotiations lead to redundancies, inefficiencies, lost time, and increased costs of labor, goods, and services[9,12,13,14].

Americans are broadly supportive of universal health insurance coverage[15,16]. In recent years, the AMA has repeatedly reaffirmed its commitment to achieving universal health insurance coverage for all Americans (H-165.838, H-165.920, H-165.845, H-165.904). Despite this general consensus in the AMA and the public that a universal health insurance system is a desirable long-term goal, employer-sponsored insurance, the cornerstone of the current system, is intrinsically incapable of providing universal coverage, as the elderly, infirm, and unemployed cannot benefit. Additionally, the Affordable Care Act only requires employers with 50 or more full-time equivalent employees to provide health coverage for their workers, meaning that a substantial number of workers do not have access to insurance coverage through their job[17]. Some workers whose employers do offer healthcare coverage may not be able to afford the costs of available plans. A 2019 Kaiser Family Foundation survey of employer-sponsored health insurance beneficiaries found that 40% had difficulty affording some component of health insurance costs, including the premium, the deductible, and other expenditures[18]. For most individuals ineligible for or unable to afford employer-sponsored insurance, only Medicare, Medicaid, or private insurance purchased directly over the ACA's state-run Health Insurance Marketplaces ("insurance exchanges") are available alternatives. These options are themselves imperfect and each incapable of providing universal coverage on their own. Medicare, for example, only covers people over 65, certain people with disabilities, and patients with end-stage renal disease[19]. Medicaid, meanwhile, is means-tested at income levels set by individual states. These eligibility limits can be as low as a fraction of the federal poverty limit in some states, and low-income single adults in those states may not be eligible at all[20]. The individual plans sold on the ACA's insurance exchanges, meanwhile, can be prohibitively expensive for consumers not eligible for the tax subsidies intended to shoulder some of the financial burden of premiums and cost-sharing requirements[21,22]. In light of this patchwork and incomplete system built upon a source of insurance constitutionally incapable of providing universal or near-universal coverage, namely employer-sponsored health insurance, it should come as no surprise that 27.5 million people, or 8.5% of the US population, was uninsured for the duration of 2018, a number that is expected to continue to rise[23,24].

Employer-sponsored health insurance persists as the bedrock of the American healthcare system due to key tax incentives that make it economically attractive for workers and companies. Premiums paid on behalf of employees by employers are 100% tax deductible as a business expense[25]. The tax deductibility of insurance premiums may encourage employers to purchase more expensive plans than they actually need, especially given how often benefits packages are used to attract new employees. Additionally, for most individuals on employee-sponsored health plans, premium payments can be made with pre-tax income, significantly reducing the tax burden on employees by eliminating the requirement that payroll and income taxes be paid on the amount of income used to pay for the health insurance premiums[26,27,28]. Companies can do this by establishing a so-called "cafeteria plan" based on Section 125 of the tax code. These cafeteria plans allow employees to make pre-tax contributions that can be used to pay for health insurance premiums and other qualified medical costs[29,30]. By shifting income from taxable gross income to a tax-deductible expenditure, Section 125 of the tax code provides employees a massive financial incentive to participate in employer-sponsored health plans. Because the net value of the tax deduction increases at higher marginal tax rates, this deduction benefits employees in higher tax brackets more than it does those in lower tax brackets[26,27]. Far from helping to reduce income and wealth inequality, this tax break, which costs $350 billion annually, is regressive and disproportionately funnels tax relief to individuals

of higher incomes[31]. The counterpart program for individual healthcare expenditures, the healthcare savings account (HSA), also allows individuals to set aside money on a pre-tax basis to pay for medical expenses, but crucially does not include health insurance premiums on the list of qualified expenses that HSA money can be used for, with select exceptions[32]. Thus, the incentive structure created by the tax code makes employer-sponsored health insurance plans artificially attractive for employees.

Employers in the Current System

A Conundrum for Smaller Employers

In 2020, there is incredible diversity in the types of employer-sponsored health insurance, and employers often face problems when determining who to cover and how to pay when it comes to health insurance. Employer-sponsored health care plans are not created equal. Those who work at large corporations may enjoy good health care coverage, but those who work with smaller employers may find themselves priced out of insurance. One survey showed that people who work at companies where a large share of the employees are low-wage workers pay an average of $7,000 annually for a family plan, about $1,000 more than those working at companies made up of better-paid workers[33,34]. In addition, with rising healthcare costs, companies face the dilemma of upping deductibles or upping premiums. Some workers may decide to quit, as a result of having so much of their paycheck going towards premiums and then still having to pay out-of-pocket costs[35]. In the perspective of the corporation, this would adversely affect employee turnover rate and productivity, in addition to being a problem for the labor market at large.

Coverage Decisions for Employers

Eligibility for coverage in healthcare plans can be an important consideration for businesses as well. Some businesses which are considered part of the gig economy, like Uber or Lyft, may find innovative ways around providing health insurance for their workers to cut costs[36]. Crucially, benefits account for about 30% of total employee compensation costs, with health insurance being one of the largest components of benefits[37]. However, regulatory frameworks on the benefits businesses are required to provide their employees are constantly shifting, which has been recently seen with California looking to expand benefits for gig workers[38]. This uncertainty may place unexpected burdens on companies, affecting their financial health and outlook. Furthermore, there are industries where healthcare insurance is just not seen in general, even with people working full-time. For example, more than half of roofers nationwide don't have health insurance. These rates are similar in the construction industry[39]. Excluded from Medicaid or Medicare and unable to afford exchange plans, these individuals may eventually contribute to uncompensated care[40]. The costs of this uncompensated care is passed on to employers, contributing to rising healthcare costs in the nation more broadly.

Rising Drug Prices

Rising pharmaceutical prices have drawn attention to the weaknesses of having a system with employer-sponsored insurance. With increasingly expensive drugs – the most famous recent example being Zolgensma, a gene therapy drug for spinal muscular atrophy priced at $2.1 million – arriving on the market, concerns have emerged among employers about payment options for these drugs. For example, smaller employers may not be able to absorb costs of these astronomically expensive drugs, and also may not have existing stop-loss insurance coverage[41]. "It's not the first gene therapy drug that concerns me the most," one executive said. "It's the 10th or the hundredth or the thousandth gene therapy drug that would concern me."[42] The feasibility of employer-sponsored insurance becomes a key question as drug prices continue increasing and as employers struggle with payment strategies. Increased usage of

stop-loss coverage would only further complicate health care financing and add an additional overhead cost.

Lack of Expertise When Attempting to Self-Insure

One disadvantage of employer-sponsored insurance is the lack of expertise and in-depth understanding in those who lead employer-sponsored health plans[43,44]. This problem is exacerbated by the approximately 49% of health plans that are self-funded or mixed-funded[45]. Historically, employers have shown little interest in the quality of health care provided to their employees, focusing instead on costs – specifically deductibles, which are easier to understand from the perspective of employers[44]. Executives may not have the time and patience to dive deeply into accountable care organizations, value-sponsored purchasing, and outcomes-sponsored pharmaceutical pricing[46]. As a result, while there has been national attention on mounting health care costs in recent years, it remains that many employers lack the staff, expertise, time, and patience to navigate the complex landscape of healthcare markets. This contributes to the significant rise in deductibles for employer-sponsored insurance over the last few years[47].

The Price of Innovation

A common advantage attributed to employer-sponsored insurance is that the existing system facilitates cost-cutting and time-saving innovation and experimentation, with managed care serving as the marquis example[43]. Unfortunately, in 2020, innovation has been outpaced by increasing costs within the existing employer-sponsored insurance framework. For example, national data shows an overall slowdown in cost growth, but this slowdown is not evenly distributed. Between 2007 and 2014, Medicare spending decreased by 1.2% per capita, whereas spending in private insurance increased by 16.9% per capita[48]. These costs are then often passed onto individuals in employer-sponsored insurance plans through high deductibles and premiums. At the same time, the public sector (from education to health care) has been showing increasing innovation as their budgets have been cut, forcing them to engage in novel ways to continue delivering their services[49]. Thus, a system relying on employer-sponsored insurance might not be the only option to deliver lowered costs and improved efficiency in health care.

Individuals in the Current System

While employer-sponsored health insurance is intended to benefit employees, the cost and logistical challenges of switching insurance has increasingly become a burden. Today, employees are sometimes forced to make career decisions due to the cost of their health coverage rather than their aspirations or skill sets. The role of the gig economy as a gap in ESHI also adds complexity. Not all health insurance pays the same, and those with the fewest resources are often left having to pay the most.

In 2019, the annual cost of a family insurance plan surpassed $20,000, with workers on average paying $6,000 towards their coverage, and average deductibles surpass $1,600[50]. The harsh reality is that these premiums are projected to continue to rise in 2021 by anywhere from 4 to 40%, despite a net decrease in healthcare costs due to delayed and cancelled care secondary to the COVID-19 pandemic[51]. Indeed, this 54% total increase in premiums over 10 years has far outstripped the wage increase of 4%. The high cost of ESHI poses a growing burden for employees.

The trend towards self-funding for insurance means that larger companies are able to offer better benefits, as 61% of employees are in a plan that is partially or fully self-funded, including

80% of employees in large firms but only 17% of employees in small firms[52]. While individuals that are higher paid or part of a union tend to be satisfied with their health coverage, those making $25,000 or less (36 million individuals in the U.S.) have the potential to be priced out of coverage[53]. However, even for those satisfied with their health insurance, job lock contributes to hesitancy pursuing alternative career choices. 56% of employees say that their current health insurance factors into decisions around new job offers[54]. Furthermore, the transition between jobs which may be covered by COBRA, is underutilized because the added cost of covering the portion of ESHI that is employer-subsidized is prohibitive for most[55]. What should be a good idea in principle frequently does not meet its promise in practice.

While many are satisfied with their health insurance, the ~20% that are not satisfied cannot be ignored. One third of the lowest quintile of employees by wage distribution are offered health insurance, but only 20% accept it due to the cost, whereas 80% of workers in the top quintile are offered and choose to accept insurance[54]. In other words, the opt-in gap for ESHI is much wider for the lowest quintile of wage earners than the highest. Indeed employees sometimes rely on being able to choose or pay for lower-cost options than what their employers offer, sometimes refusing raises or full-time employment[53]. Similarly, in the gig economy employees have the flexibility to work when and how they want to, and employers are not required to offer health benefits as a result. However, recent legislation in California has begun to challenge this paradigm and may leave gig workers without employment if the businesses are unwilling to adapt[56].

Concerns about how decoupling employment and insurance would lead individuals to avoid seeking work are likely overstated. There may be a push to people changing jobs but the overall labor supply is unlikely to be substantially impacted. Individuals reliant on part-time jobs, most often those of lower SES, would especially benefit as more options became available. Finally, at a time when larger scale changes such as expanding Medicare are being considered, replacing employer-sponsored insurance with alternative sources would be a more moderate change.

ESHI while it is an attempt to support and maintain employees may not achieve its aim as it is high cost and inequitably distributed. Furthermore, its long-term health benefits remain unclear. The high cost of insurance actually disincentivizes patients going to their physicians even when the visit is free, producing worse health outcomes in the long-term[51].

Alternatives

There are four major healthcare models - Beveridge, Bismarck, national, and out-of-pocket. Our national healthcare design incorporates features of each of these four models.

The Beveridge model embraces a centralized design in which the government is the only provider of health insurance. There is no competition and the government controls what providers can charge. This paradigm characterizes nations like Spain and the United Kingdom. Part of the attraction of this model is that it encourages more robust preventative health services. Additionally, there are no out of pocket costs for citizens and there is no need for any cost-sharing mechanisms. The drawbacks, however, are high taxes, the risks of overutilization, and funding problems during national economic and public health crises.

The Bismarck model employed in Germany offers a number of valuable examples through which public and private coverage mechanisms can successfully provide near-universal coverage. While most health insurance plans are funded by payroll taxes paid by employers and employees, this is where the similarities to employer-sponsored health insurance in the United

States end. Payroll tax contributions are paid into a general fund, which is divided between competing, not-for-profit so-called “sickness funds” that administer healthcare to the majority of German citizens, who can choose between sickness funds. The option to purchase private health insurance in lieu of participation in a sickness fund is available for those making above an income threshold. The government plays little direct role in the provision of care, which is largely devolved to sickness funds and private insurance providers[57].

The national health insurance model is a hybrid of the Beveridge and Bismarck models in which the government is the sole provider of health insurance and the providers are private-sector based. Although a fraction of citizens purchase private insurance to cover a suite of services that are not covered by universal insurance, most key diagnostic exams are included. Additionally, because the government processes all of the claims, administrative costs are sharply reduced. Drawbacks of this system include significant wait times. This model is used by countries like Canada and Taiwan.

The out of pocket model is the design most common in most developing countries without a mature health care system. In this model, patients must pay for procedures and professional health care out of pocket, leaving many without any health services at all. This model is seen in the poorer parts of the world. Under this system, socioeconomic disparities translate to dramatic health disparities.

EXHIBIT 1

Comparison of the National Healthcare Systems Countries predominantly use one of four healthcare models.

	Beveridge	Bismarck	National Insurance	Employer Insurance
Coverage	Universal	Universal	Universal	Primarily employees, some groups covered by public systems
Insurer(s)	Single-payer with opt-out for private insurance	Multipayer private with some public	Single-payer with no opt-out for basic care; private for additional care	Private with single-payer for some groups
Funding	Tax deductions on salary	Premiums through tax deductions plus employers' contributions	Tax deductions on salary; employer contribution on private	Premiums paid by employers and employees; single-payer systems publicly funded
Service Providers	Both public and private service providers and hospitals	Both public and private service providers and hospitals	Private service providers; public and subsidized private hospitals	Ownership and administration of service practices and hospitals vary by system
Advantages	Short wait times; many private options	Short wait times; costs shared by taxpayers and employers	Low out-of-pocket expenses	High-quality care for those who have access; very high in technical innovation
Disadvantages	Rural areas underfunded, understaffed, underserved.	Costs rising due to changing demographics	Long wait times for nonbasic, nonemergency services; long waits in emergency rooms	Many people uncovered; extensive care can lead to financial ruin; high per-capita expenditure
Countries (with WHO ranking of quality of healthcare)	2 Italy 11 Norway 18 United Kingdom 23 Sweden 32 Australia	1 France 9 Austria 10 Japan 17 Netherlands 20 Switzerland 25 Germany	30 Canada 58 South Korea	37 United States

Source: Morningstar. 58

The aforementioned systems offer instructive paradigms for the United States to consider as talks of significant health system reform increase in Congress. All of the above have achieved universal or near-universal health coverage with significantly lower associated costs and can serve as alternatives to employer-sponsored health insurance. For example, automatically enrolling everyone in a Medicare or Medicaid policy regardless of income level would be similar to the Beveridge or national health insurance model as seen in the United Kingdom and Canada

respectively. In the absence of a single-payer system, strengthening the health insurance exchanges could prove vital to attaining near-universal or universal coverage. A Medicare buy-in option, while not as expansive as a single-payer model, would permit 55-64 year olds to buy into a less costly policy and presumably reduce premium costs for younger adults in the individual marketplace by removing higher-risk enrollees. A public option could have a similarly moderating effect on the premiums in the individual marketplace creating more competition in health insurance exchanges offering those who relinquish employer-sponsored coverage more options and lower premiums[59].

All of these alternatives offer a pathway to more comprehensive coverage of the US population than a system based on EHSI. They also offer avenues to contain prohibitive costs by reinvigorating the market forces in existing exchanges that have been continually eroded and distorted by EHSI.

The Impact of COVID-19

The stress of the COVID-19 pandemic has highlighted the glaring deficiencies of the employer-sponsored health insurance. The economic downturn has paradoxically led individuals to lose their health insurance and access to care amidst this public health catastrophe. Employer-sponsored health insurance has served as the largest source of health coverage for Americans, covering 67.3% of Americans (178 million) in 2018; however, ESHI is especially vulnerable during times of economic crisis when unemployment rises[60]. During March through June 2020, a net of 6.2 million workers have already lost access to health insurance previously received through their employer[61]. Revised estimates suggest that 10.1 million workers and families will lose employer coverage due to a COVID-19 related job loss during the last three quarters of 2020, one-third of which will be uninsured (3.5 million)[62]. While those who have lost health insurance through their employer may pay for continued temporary coverage under COBRA or qualifying public insurance, switch to a family member's policy, or access insurance through ACA marketplace exchanges, ACA/COBRA premiums are often cost prohibitive and many are unaware that they are eligible for Medicaid[63,64]. This loss of coverage leads to decreased access to care, which increases the risk for delayed management of chronic conditions, reduced preventive care, or delay in care for COVID-19 itself. The uninsured are also at risk of incurring high costs associated with COVID-19 testing and treatment and delaying care; nearly 14% of Americans said they would avoid medical care due to cost if they developed symptoms consistent with COVID-19, and recognizing this burden, Congress also passed the Families First Coronavirus Response Act in part to expand coverage of COVID testing[60,65]. Unemployment has disproportionately affected workers paid low wages, families with low income, women, and persons of color, further underscoring the structural inequities in the US and exacerbating the health inequities[66,67,68]. The surge in unemployment stemming from the COVID-19 pandemic has demonstrated how the employer-sponsored health insurance model is especially vulnerable, and this shared, national trauma can be used as an opportunity to critically assess and improve our healthcare system.

DISCUSSION

By creating a disconnected, fragmented system with a multitude of insurance providers, redundant systems, and a bevy of opaque price negotiations that limit transparency and competition, employer-sponsored insurance directly contributes to the high costs of US healthcare, both by magnifying administrative costs and increasing outlays for labor, goods, and services. This system is held up by a series of overwhelming tax incentives that reduce the ability of employees to shop for competitive alternative insurance products outside the plans

offered by their employers, in direct contradiction to the principles of competition and free choice. Additionally, far from providing a safety net for ambitious Americans, employer-sponsored health insurance ties healthcare to work, increasing the risks associated with entrepreneurship and job loss. Further, by tying employment to health insurance, employer-sponsored health insurance significantly limits the ability of The requirement for employers with greater than 50 employees to offer healthcare coverage also places an undue burden on employers, who are forced to produce the requisite bureaucracy to either identify the best health plans for their employees or to self-insure.

While these weaknesses of the current system were always present, the COVID-19 pandemic has highlighted its fundamental flaws in stark contrast. By tying insurance to employment, America ensures that economic anguish is always paired with health insecurity. During natural disasters and pandemics where the need for healthcare becomes acute, this maladaptive systemic quirk rips healthcare coverage from people when they need it most, adding new, entirely preventable dimensions to public health catastrophes.

Employer-sponsored health insurance forms the foundation of America's healthcare system due to a twist of history, but it does not have to be this way. Multiple alternative national models of healthcare delivery exist internationally, ranging from single-payer systems as exemplified by the UK and Canada, universal systems based on private insurance as seen in the Netherlands and Switzerland, and countries like Germany with mixed public-private healthcare providers in between. While these health systems are all unique and display remarkable variation in the particulars of their implementation, they all have one thing in common - they do not rely on employers to provide health coverage for the majority of their citizens. Without exception, these alternative models of health insurance coverage are less expensive, simpler and easier to navigate, and more flexible than the American model of employer-sponsored health insurance. Though it would be practically impossible to directly import the health system of any single peer country into the United States, the relative successes of these varied national systems conclusively demonstrate that superior, comprehensive alternatives are possible to design.

Our AMA has historically been supportive of improvements to our current system, which is inclusive of employer-sponsored insurance, Medicare, Medicaid, and the individual market established by the ACA. For example, in H-165.843, our AMA encouraged employers to "support increased fairness and uniformity in the health insurance market." Furthermore, our AMA has promoted transparency in ESHI, such as in H-155.961, where our AMA encourages "employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts." Finally, our AMA has looked to make ESHI more affordable with H-165.828, where, for example, our AMA "supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-sponsored or employee-only coverage." These policies, and others, demonstrate the AMA's commitment to improving the American healthcare system by expanding coverage and access, reducing costs, and improving outcomes.

CONCLUSION

Employer-sponsored health insurance massively increases the cost of health insurance in the United States, and so exploring other options for health insurance delivery may illuminate

avenues to reduce the healthcare costs which have risen unabated in the US for decades. A more streamlined system would also help to improve both the quality of and access to care by enhancing accountability and transparency, reducing the number of entities responsible for providing healthcare coverage to Americans, and reducing the number of gaps in the system by simplifying the forms of health insurance currently available. By decoupling insurance and employment, transitioning to different sources of health insurance coverage would improve the American public's ability to weather employment shocks, such as those seen in the Great Recession and the current pandemic. While the preponderance of the evidence suggests that employer-sponsored health insurance is an insufficient model to meet the health and economic needs of the American people, multiple potential alternatives exist, each with their own distinct strengths and weaknesses. For these reasons, any transition away from employer-sponsored health insurance will have to carefully consider the nature of the system intended to replace it and the way in which said transition will be accomplished.

RECOMMENDATIONS

Your Committee on Economics & Quality in Medicine recommends that the following be adopted and the remainder of this report is filed:

1. RESOLVED, That our AMA support transitioning away from a system that relies on employer-sponsored health insurance to facilitate universal access to high quality, affordable healthcare.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND COMMITTEE ON BIOETHICS AND HUMANITIES

MSS CGPH CBH Report A
(November 2020)

Introduced by: MSS Committee on Global and Public Health and Committee on Bioethics and Humanities

Subject: Support for Assisted Outpatient Treatment

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At its Interim 2019 meeting, the AMA-MSS referred for study MSS Resolution 56 entitled "Support for Assisted Outpatient Treatment." The resolve clause was as follows:

> RESOLVED, That our AMA supports the use of assisted outpatient treatment as a method of intervention for individuals with serious mental illness at the state and local level in the United States.

Testimony on the Virtual Reference Committee was varied and divided. The Reference Committee recommended non-adoption, citing concerns about the differences between "assisted outpatient treatment" (AOT) and "involuntary outpatient commitment" (IOC) as well as conflicts between this resolution and the American Psychiatric Association (APA)'s stance. The Reference Committee recommended this issue would be better raised by the APA or in collaboration with the APA. The authors extracted this resolution for debate in the MSS Assembly. Testimony in the Assembly demonstrated some confusion about what AOT entailed, how it is enforced, and how the proposed resolved clause would benefit the AMA or complement or contradict the stance of the APA.

Your Governing Council assigned this report to the Committee on Global and Public Health (CGPH) and the Committee on Bioethics and Humanities (CBH) with the following objective: To determine whether the MSS should ask the AMA to support using AOT as a method of intervention for individuals with serious mental illness at the state and local level.

In this report, we begin with a brief overview of the problems this resolution attempted to address. Subsequently, we establish the most accurate terms for this issue, the effectiveness of the treatment in question, the positions experts have taken, and the public health effects and ethical dilemmas involved. We discuss whether the evidence indicates that the AMA-MSS or the AMA should take a stance on this issue and how the stance of the APA in addition to the various ethical dilemmas should and do affect our stance. We consider three potential avenues of action the AMA-MSS can take to address this issue. This is followed by our recommendations for the AMA-MSS on the optimal stance to take to best protect and enhance the health, well-being, and rights of individuals with serious mental illness.

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BACKGROUND

Severe mental illness and its treatment have come under increased public scrutiny due to lack of appropriate support and resources. Specifically, there is a growing subpopulation of patients who require complex care but are non-adherent to treatment, often as a result of systematic failures that impede access to care. A variety of solutions have been proposed to address this issue, including assisted outpatient treatment, a form of involuntary outpatient commitment, discussed throughout this report.[1]

Definitions and terms

Involuntary outpatient commitment (IOC) is defined by the APA as "a form of court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to adhere to treatment without such a program." The APA indicated that IOC can be used in a number of cases, including preventive treatment in those not currently meeting criteria for involuntary hospitalization, as an alternative to involuntary hospitalization, as a transition back out of involuntary hospitalization, or to prevent a patient's relapse or a patient's behaviors that are dangerous to the patient or others.[1] In the United States, this treatment scheme was introduced by the enactment of "Kendra's law" in New York in 1999, and is now allowed in various forms in 42 states.[32]

Assisted outpatient treatment (AOT) is used, legally, to refer to the same practice as IOC. However, the term "assisted outpatient treatment" has been criticized as a euphemistic term, given that it refers to treatment under coercion. For this reason, the APA prefers to refer to the practice in question as IOC, rather than AOT.[1] In order to avoid confusion between terms and to bring our report into concordance with the language of the APA, we will use the term involuntary outpatient commitment or IOC throughout the rest of this report, unless referring to studies in which the specific term "AOT" is used.

Effectiveness of IOC and Public Health

The practice of IOC has now been studied for over three decades, yet there is little consensus about its effectiveness, and its implementation has been limited.[2,3] Results of existing studies on IOC are mixed and conclusions are contested.[3–6] One researcher commented that IOC cannot be studied like other treatments because IOC's success is so dependent upon how it is implemented and applied.[5]

Randomized controlled trials studying IOC are especially difficult to conduct due to ethical concerns and administrative barriers.[3] Of the randomized controlled trials attempted, the Bellevue study found no benefit to IOC; the Duke Mental Health Study found that patients in their system assigned to IOC were less likely to be rehospitalized, had fewer hospital days, and were reported to have lower rates of violent behavior compared to controls; the UK OCTET study found no benefits in the UK's version of court-ordered IOC (however, this study is widely believed by experts not to be applicable to studies of IOC in the US due to certain non-comparable metrics).[3,6,11,12,13–15]

Proponents of IOC tout one study of the New York AOT program which found that, although it is more expensive in the short term, AOT reduces the total cost of treatment over the course of the first year.[24] Other outcomes included reduced hospital admissions and reduced length of stay, increased appropriate use of psychotropic medication and intensive case management services,

and greater engagement in outpatient services.[4] In New York, the combination of AOT and intensive services was found to provide benefits compared to the provision of intensive services alone.[4]

A general benefit of IOC is that it may provide treatment in a setting less restrictive than involuntary hospital admission, such as in "step-down" models of treatment.[3] Another potential benefit of IOC is that it concentrates resources and provider attention for patients who are severely ill.[1] Studies have shown that when IOC works, it requires the inclusion of two vital factors: (1) the collaboration of the courts, and (2) the application of intensive treatment resources.[5] Surveys of people receiving IOC have shown an increase in perceived quality of life and satisfaction with the treatment program.[7,8]

However, the effectiveness of IOC must be newly evaluated in each new population to which it is applied, as it may not be equally effective for all forms of serious mental illness. When used for patients suffering substance use disorders, IOC has been found not to be useful.[9] A concern about IOC is its possible expansion into "preventive" IOC for people who are not mentally incompetent nor imminently dangerous and who have broken no laws.[4,10] Further, effectiveness of IOC as a treatment appears to be highly dependent on its effective implementation.[3] Another challenge of treatment with IOC is that it is possible the concentration of these resources deprive others who are not under court order of receiving the resources they need.

Public Safety

One study of the New York AOT program found that, of those under AOT, 10.4% reported an act of violent behavior in the past 6 months compared to 15.7% of patients who received intensive voluntary services.[5] For patients receiving AOT, the adjusted predicted probabilities of arrest was 1.9%, compared to 2.8% for those on intensive voluntary services, and 3.7% for individuals who had not yet initiated any treatment.[5] Physical assaults by AOT participants were reduced from 8% to 4%, and incarceration was reduced from 19% to 7% in a retrospective program study involving approximately 9000 patients.[5] Still, some patient advocate groups are hesitant to embrace AOT based on empirical evidence from this single program in New York.

Major psychiatric conditions like schizophrenia and mood disorders, by themselves, contribute relatively little—about 4%—to the overall risk of interpersonal violence in the general population, and most perpetrators of commonplace violent acts do not have serious psychopathology.[16] Although studies indicate there is a slightly elevated risk of violence in persons with severe mental illness, such acts remain rare.[16,17] Persons with mental illness are in reality more frequently subjected to physical or sexual victimization, and these experiences compounded by other psychosocial factors may increase the risk of violence perpetration against these populations.[5,18–23]

Position of the American Psychiatric Association

When considering all the evidence, expert researchers and the American Psychiatric Association (APA) determined the success of IOC to be largely dependent upon: (1) investment in effective implementation, (2) availability of intensive community-based services, and (3) duration of the court order.[1,3] The following is the stated position of the APA, given in their Resource Document on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment, published by the APA Council on Psychiatry and Law.

> "Involuntary outpatient commitment can be a useful intervention for a subset of patients with severe mental illness who 'revolve' in and out of psychiatric hospitals or the criminal justice system. These individuals often improve when hospitalized and treated, but frequently do not adhere to treatment after release, leading to a cycle of decompensation, re-hospitalization and, in many cases, arrest. Although important studies of involuntary outpatient commitment have been conducted within the past decade, there is no broad consensus about its effectiveness across jurisdictions. However because it is a complex community-based intervention, implemented in diverse local communities, its effectiveness would logically be expected to vary. Research in this field also faces substantial methodological problems. It is difficult to separate the effects of the court order and the legal authority of the court from the effect of improved access to appropriate services. In fact, some advocates and persons with mental illness argue that both improved services and better access to services without a court order could yield comparable outcomes to those obtained by successful involuntary outpatient commitment programs."

Given the ethical tensions between autonomy and beneficence introduced by IOC, the APA recommends IOC only be used after every effort has been made and all resources possible are dedicated toward voluntary treatment.[1]

Ethical Dilemmas Associated with IOC

Since IOC is a fundamentally coercive practice, the topic comes with its own controversies and ethical dilemmas to consider. In a report by the Substance Abuse and Mental Health Services Administration (SAMHSA), the authors discuss 4 bioethical principles relating to IOC: 1) respect for autonomy, 2) non-maleficence, 3) beneficence and 4) justice.[25] For this report, we will focus on autonomy and beneficence, as the remaining principles may be beyond our scope.

Involuntary commitment in general, creates a significant restriction on personal liberty that is often not seen outside of the criminal justice system.[25] Of course, to mandate treatment against one's will is to initially violate the principle of autonomy and, as the authors of this report note, many will argue that it takes significant circumstances and significant potential for harm to violate this principle. While being a threat to others or to one's self is justification for involuntary hospitalization, some may argue that by definition, those who are "outpatient" do not pose such an immediate threat.[25] A counter argument however, is that IOC may actually *promote* autonomy through access to and implementation of effective treatment that would restore reliable decision making.[25] In other words, IOC can be seen as a means to an end of autonomy itself. Another counter argument presented by SAMHSA is the position that the often alternative to IOC is repeated involuntary hospitalization or incarceration which is more restrictive to autonomy in the end.[25] In other words, while it is restrictive, IOC may be the *less* restrictive option. Both counter arguments however, rely on the *effectiveness* of IOC and the harms of mandatory treatment should be balanced against the benefits for the patient.

We will next address the principle of beneficence, or providing significant benefits to balance risk.[25] The concept of medical paternalism is usually employed here - the idea that the physician make decisions based on what is "best" for the patient.[26] Such a principle usually favors beneficence over autonomy when the two collide, and can offer support for IOC.[26] In terms of benefits that balance risk, SAMHSA notes that IOC may provide substantial good by leveraging

resources and treatment options for individuals in a constrained mental health system.[25] However, the ethics or justification of using IOC as a means to an end is beyond the scope of this section, but is important to consider when dealing with the contrasting autonomy of an already vulnerable patient population.

Practically, public policy landscapes affect the availability of treatment for mental illness, which in turn dictates the type of treatment that patients receive. For example, in areas with greater numbers of psychiatric beds, rates of involuntary hospitalizations are higher, whereas areas that prioritize comprehensive voluntary care have fewer involuntary commitments.[26] Bearing this in mind, the MSS has an opportunity to choose our priorities on this issue. We may choose to emphasize the benefits of expanded voluntary treatment for mental illness, or draw attention away from expanded voluntary treatment by advocating for IOC.

DISCUSSION

Evaluating involuntary outpatient commitment (IOC) is a difficult task due to the highly variable implementation and practice of this broad subset of mental health treatment. Regulations around IOC vary depending on state and local governance, the populations being treated are inconsistent, and practices vary among institutions in which it is being used. The best data available seem to indicate IOC can be a useful treatment modality for some patients but ineffective for others (e.g. patients with substance use disorders). The extrapolation of research findings to all circumstances is inappropriate.

Advocates for the use of IOC assert there is a subset of persons with impaired functional decision-making capacity for whom involuntary treatments can help restore full mental faculties and help them gain independence. Short-term treatment with IOC can potentially protect these patients from exploitation and improve their quality of life, warranting its use in certain situations. Specifically, the American Psychiatric Association (APA) supports policies that permit IOC in cases where individuals with a history of mental health decompensations have been unable to commit to a therapy plan. The organization acknowledges that increased access to mental health resources and additional community support is of primary importance, but deems IOC necessary for patients whose lack of decision-making capacity may be harmful to them, leading to “a cycle of decompensation, re-hospitalization and, in many cases, arrest.”

Public safety and stigma, conflating mental illness with a propensity for violence, further stereotypes mental illness and should not be used as a mainstay argument for this topic.

An exceedingly small proportion of violent crimes are perpetrated by individuals with psychiatric conditions, though studies have shown a decrease in crime when IOC was implemented.

This committee believes that it is important to advocate for a human rights-driven approach rather than a paternalistic model of mental healthcare. Within a human rights-driven approach, there can still be room for supporting IOC, but we conclude that implementing IOC should be done under high levels of scrutiny, applied for the shortest time possible, and only be entertained once all other voluntary options have been exhausted. Efforts should also be made to expand access to high quality individual and community mental health resources for all, so that voluntary treatment continues to remain the cornerstone of mental healthcare, and the sufficient course in the vast majority of cases. Furthermore, it is vital going forward to improve the quantity and quality of data collected on the efficacy of IOC to inform future policy decisions.

Given the above, your CGPH and CBH considered three possible outcomes of this report: (1) taking the reference committee’s recommendation to not adopt; (2) adopting a set of resolved

clauses adapted from APA language as AMA-MSS policy to be proposed at the AMA HoD meeting in June 2021; and (3) adopting a set of resolved clauses adapted from APA language as internal AMA-MSS policy.

The members of these committees agree there is sufficient evidence to support some kind of AMA-MSS or AMA policy on IOC, as long as the language in our policy is no stronger than that used in the statements of the APA. Given that the MSS is not the subject expert in IOC, however, we are concerned that bringing this resolution to the HoD may be out of our scope.

We concluded that if it is appropriate for the AMA as a whole to take a stance on this subject, then the most appropriate body to bring forward such a resolution is the APA. Given that the APA has policy of its own on IOC but has chosen not to bring forward such a resolution into the HoD, and given that policy experts in the APA did not encourage us to bring this resolution to the HoD and some expressed uncertainty even about the APA's position, we have concluded that it would not be appropriate for the MSS to propose this resolution to the HoD at this time.

We believe this resolution is most appropriate as an internal policy, lending guidance to the MSS in any future policy actions by the HoD.

CONCLUSION

IOC can be a useful treatment modality for a subset of the seriously mentally ill when implemented correctly. The American Psychiatric Association supports the use of IOC for certain patient groups and also supports use of the term "involuntary outpatient commitment" rather than "assisted outpatient treatment", given concerns that the latter is euphemistic. The effectiveness of IOC has been very difficult to study, but existing research has indicated IOC may provide benefit for some subsets of patients, such as for those with non-affective psychotic disorders. IOC provides public health benefits, but these must be weighed against ethical considerations such as beneficence in treatment and patient autonomy. The use of IOC should be highly regulated and reserved for use on a case-by-case basis, with continuing review, for sub-populations of patients for whom other options have been exhausted.

RECOMMENDATIONS

Your Committee on Global and Public Health and Committee on Bioethics and Humanities recommend that the following resolve clauses be adopted in lieu of the original resolution and the remainder of the report be filed:

> RESOLVED, That our AMA-MSS recognizes that involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness when all other voluntary means of and barriers to treatment have been explored; and be it further
>
> RESOLVED, That our AMA-MSS supports the monitoring of the effectiveness of local and state involuntary outpatient commitment programs in conjunction with study of barriers to success of voluntary outpatient mental healthcare treatment for individuals who are

chronically non-adherent for further research and understanding of evidence-based practices.

Additionally, we recommend the title of this resolution be changed to “Use of Involuntary Outpatient Commitment.”

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E-9.7.2 Court-Initiated Medical Treatments in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm. In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Principles of Medical Ethics: I, III; Issued: 2016; Mod: 2017.

The AMA's Principles of Medical Ethics highlights the moral obligations of physicians to honor voluntary and informed consent when providing medical care that has been ordered by a court (E-9.7.2).

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND MINORITY ISSUES COMMITTEE

MSS CGPH MIC Report A
(November 2020)

Introduced by: MSS Committee on Global and Public Health and Minority Issues Committee

Subject: Reimbursement of School-Based Health Centers

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

After the 2020 MSS Annual Meeting, a Governing Council Action Item entitled, "CGPH Report on School-Based Health Centers," asked to study the outcomes of school-based health centers (SBHCs) and provide recommendations on how the AMA can advocate effectively for increased reimbursement of these centers in the current regulatory landscape. The AMA MSS GC believes that advocacy related to this issue could be strengthened through an assigned report.

Specifically, the goal of this report is to answer the following two questions: Are school-based health centers (SBHCs) effective at delivering equitable health care in America? What factors enable/inhibit their implementation? These will be answered through a thorough review of the existing research on SBHCs and through critical analysis of the information that has been put out by leading experts on the topic. We will consider the nuanced nature of healthcare delivery in different parts of the country and apply this to our assessment. With this information, we hope to develop an updated AMA policy that appropriately responds to scientific consensus and promotes equitable health care as it relates to SBHCs.

BACKGROUND

Definitions

School Based Health Centers (SBHCs) are facilities located within the academic setting that provide an array of high quality health care services to students. The services available at SBHCs are driven by community need and have the capacity to function as a primary medical home to patients that lack alternative resources. SBHC services are interdisciplinary and can range from primary medical care to dental, vision, and behavioral health services, alongside wraparound programming such as substance abuse counseling and social case management.[1] SBHCs can also function as a tool for health promotion through student health education. The SBHC model has been demonstrated to provide students with increased access to health care resources and improved long and short term health care outcomes.[2]

Medicaid is a federal and state program established by the Social Security Act of 1965 that provides health insurance coverage to Americans that qualify based on low income or disability status. The Centers for Medicaid Services (CMS) oversees execution of Medicaid by providing regulation and quality metrics. States contract with Managed Care Organizations (MCOs) to provide payment for clients and reduce overall cost.[3]

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Claims data is a compilation of billing codes that health care providers use to collect money from payers. Therefore, both Medicaid and private health insurance companies produce claims data which provides a standardized source for data collection.[4] In particular, Medicaid claims data is collected by CMS and resulting data sets can then be accessed widely for research.[5]

Financial Sustainability of School-Based Health Centers

SBHCs can receive both grant funding by private organizations and the government, and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and the Children's Health Insurance Program (CHIP). Private organizations, like the Robert Wood Johnson Foundation (RWJF), have established grant funding for the planning and establishment of SBHCs.[6] Similarly, federal, state and local governments have established direct funding programs for SBHCs.[7] At the federal level, the federally qualified health center (FQHC) program funds community health centers that serve medically underserved populations, such as SBHCs, by providing cash grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit reimbursement by Medicaid.[8] According a Community Preventive Services Task Force (CPSTF) Funding systematic review and meta analysis, funding for SBHCs is cost-effective because it increases access to preventive care and reduces utilization of expensive acute care services, leading to a net savings for Medicaid of $30 to $969 per visit and a societal benefit-to-cost ratio of 1.4:1 to 3.1:1.[9]

The initial strategy of many SBHCs was to pursue Medicaid reimbursement as a means of financial sustainability, however challenges in the reimbursement process have led to poor returns and many SBHCs rely on public funding.[6] A national survey of SBHCs showed that only 89% billed Medicaid and 71% billed CHIP in 2014, with others stating that costs of billing and litigating claims denials outweighed the revenues available from billing.[10] Moreover, not all services rendered can be reimbursed under Medicaid at SBHCs; among many requirements, 1) the child must be Medicaid-eligible, 2) the service must be among those covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider - further, until 2014, reimbursement was not allowed for services given without charge to the beneficiary, except under rare exceptions.[11] As Medicaid reimbursement is simplified to a per-visit payment, called the Medicaid Prospective Payment System (PPS), for SBHCs receiving FQHC program funds, participation in Medicaid is higher for this group.[10,12]

It should be noted that apart from seven state Medicaid agencies, SBHCs are not considered a provider type.[13] The reimbursement of services then becomes more difficult for SBHCs. In addition, the lack of differentiation on claims data means that Medicaid is unable to identify what services were rendered by an SBHC versus a different type of provider. Ultimately, this makes it difficult to track and attribute improvements in quality of care or outcomes to SBHCs. The regulatory aspect is then also affected, as Medicaid agencies are unable to certify that SBHCs meet quality standards expected by the state. The clear distinction of SBHCs allows for greater data collection and research on their efficacy and simplifies the reimbursement process for providers.

Current Landscape

School-based health centers have grown substantially over the past two decades, primarily due to an increase in federally qualified health center (FQHC) sponsorship. As of 2017, there are 2,584 SBHCs in the United States, which have more than doubled in number since 1998.[14] This increase has not been evenly distributed: since 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban settings.[14] The majority of students without access to SBHCs attend schools in low-income communities eligible for Title I funding.[10] Further,

while increased FQHC sponsorship has greatly contributed to recent growth, 80 percent of FQHCs are currently not partnered with SBHCs.[10]

Recent policy advancements in various states that have facilitated and/or increased Medicaid reimbursement to school-based health centers include defining SBHCs as a Medicaid provider type, waiving prior authorization, and requiring Medicaid managed care organizations to pay for reimbursement.[13] Seven states (Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia) have named SBHCs as a provider under Medicaid, and four states (Louisiana, Maryland, Michigan, and New Mexico) mandate Medicaid reimbursement through a managed care organization.[13] Eight states (Connecticut, Delaware, Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) have waived prior authorization.

DISCUSSION

The establishment of SBHCs dates back to the 1960's by the American Academy of Pediatrics in order to increase access to primary health care and preventative health services, often for the most vulnerable underserved population of children.[2] These centers are intended to facilitate social mobility and promote positive health outcomes for these underserved populations through physical and financial benefits. The success with SBHCs ability to improve health outcomes lies partly in its strategic distribution among urban, suburban, and rural areas, specifically to act as a "safety net health care delivery model" for uninsured, underinsured children or those with lack of accessible healthcare.[15] Established primarily for those in kindergarten through 12th grade, SBHCs offer a wide array of services such as mental health services, social services, dentistry, and other basics of primary care that low income youth would normally not be able to access. Due to the focus on preventative care and health maintenance, SBHCs are well suited to address the negative consequences of health disparities in low income urban and rural communities, such as depression, obesity, chronic metabolic issues, all of which contribute and are well linked to mental health disorders and reduced academic performance.[16] In a systematic review, SBHCs were also found to improve health outcomes such as substantially reduce the number of ED visits and hospital utilizations. Mostly, SBHC's have increased effectiveness at improving access to care for disadvantaged populations through extended hours of availability and increased range of the previously mentioned services to address social, financial, and related barriers to appropriate care. This offers a feasible and financially sustainable option to integrate into education and school systems while being cost effective for all parties involved.

The benefits of routine preventive care are well-established and are incredibly important for children from infancy to adolescence, providing 1) prevention of serious medical illnesses through vaccination and screening, 2) tracking growth and development, 3) raising medical-related concerns and 4) creating a strong patient-centered medical home.[17] Further, there is longstanding evidence that routine childhood prevention decreases adult disease burden in the general population and is highly cost-effective.[18,19]
Issues of implementation and delivery of healthcare through SBHCs fall within the purview of the AMA. Physicians are employed by about 40 percent of SBHCs.[10] The AMA supports physician service reimbursement and reimbursement for physician practices (H-240; H-385; H-390).

Furthermore, the AMA has already established policy supporting the study of SBHCs and recommending SBHC standards (H-60.991), and policy supporting adequately resourced SBHCs for healthcare delivery to children and adolescents (H-60.921).

CONCLUSION

In summary, your CGPH and MIC considered two possible outcomes of this report: (1) adopting a resolve clause to propose an amendment to existing AMA policy, such as H-60.921; or (2) adopting new resolved clauses on SBHCs as AMA-MSS policy to be proposed at the AMA House of Delegates meeting in June 2021. We concluded that it was most appropriate to amend and strengthen H-60.921 than to craft a standalone policy.

We propose a quadripartite amendment for H-60.921 that seeks to accomplish the following:

1) Redefine AMA's current support for SBHCs to include their implementation, maintenance, and equitable expansion. With the new language, we move beyond support for "the concept" of SBHCs to focus on how we can best extend the public health reach of these systems.
2) Recognize the role of SBHCs in increasing pediatric access to care. Our review has indicated that SBHCs have provided students with increased access to health care resources and improved long and short term health care outcomes. This is an important predicate for our subsequent asks.
3) Distinguish SBHCs from other providers in claims data. The lack of differentiation on claims data has complicated research and regulatory efforts for SBHCs with possible implications for reimbursement, quality improvement, and health outcomes. This change would greatly benefit providers serving SBHCs as well as public health researchers studying these healthcare institutions.
4) Facilitate Medicaid reimbursement for services provided by SBHCs. We show that challenges in the reimbursement process have led to poor returns and difficulties with financial sustainability despite the benefit of SBHCs to public health, with many of them relying on public funding. We therefore urge AMA to support efforts to expand Medicaid reimbursement for SBHCs. At the state level, this has taken the form of increasing Medicaid reimbursement to school-based health centers by defining SBHCs as a Medicaid provider type, waiving prior authorization, and requiring Medicaid managed care organizations to pay for reimbursement.

RECOMMENDATIONS

Your Committee on Global and Public Health and Minority Issues Committee recommend that the following be adopted and the remainder of the report be filed:

RESOLVED, That the AMA promotes the implementation, use, and maintenance of SBHCs by amending H-60.921 School-Based and School-Linked Health Centers as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.
3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND WOMEN IN MEDICINE COMMITTEE

MSS CGPH WIM Report A
(November 2020)

Introduced by: MSS Committee on Global and Public Health and Women in Medicine Committee

Subject: Enhancing Transparency and Regulation in the Personal Care Product Industry

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, MSS Resolution 36 asked the AMA to support and advocate for Congress and the FDA to legally define the term "personal care products," to research ingredients found in personal care products to better understand both the cross-reactivity of ingredients and the health effects of chronic usage of personal care products, and to establish guidelines for safe usage of personal care products. The I-19 Reference Committee recommended referring MSS Resolution 36 for study. The MSS Assembly and Reference Committee specifically had concerns regarding the following:

1. That our AMA encourage Congress and the FDA to legally define the term "personal care products";

2. That our AMA advocate for the FDA to research ingredients found in personal care products in order to better understand the cross-reactivity of ingredients, chronic usage of personal care products, and establish guidelines for safe usage of personal care products.

Both the Reference Committee and Assembly agreed that this is an important resolution that could be more thoroughly addressed through an assigned report. Specifically, we were asked to address whether the MSS should ask the AMA to amend existing policy by replacing the phrase "cosmetic" with "personal care products," and whether the MSS should amend internal policies, expanding them to all personal care products, not just cosmetic and/or feminine hygiene products.

BACKGROUND

Though not legally defined, the term "personal care products" is often used to refer to a wide variety of items that are commonly found in the health and beauty sections of drug and department stores.[1] These personal care products are regulated as cosmetics (such as skin moisturizers, perfumes, lipsticks, fingernail polishes, makeup, shampoos, permanent waves, hair colors, toothpastes, and deodorants), drugs (such as treatments for dandruff or acne, sunscreen products, antiperspirants, and diaper ointments), medical devices (hair removal and microdermabrasion devices), dietary supplements (vitamin or mineral tablets or capsules) and consumer products (soap), based on their composition, mechanism of action and marketing

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claims.[2,3] The Food, Drug and Cosmetic (FD&C) Act of 1938 charges the Food and Drug Administration (FDA) with the authority to regulate cosmetics, drugs and medical devices and their authority was expanded by the Dietary Supplement Health and Education Act of 1994 to also include dietary supplements.[4,5]

The term "cosmetic" refers to any product that is "intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body...for cleansing, beautifying, promoting attractiveness, or altering the appearance".[4] FD&C prohibits the marketing of adulterated or misbranded cosmetics and the FDA has the authority to take action against cosmetics that are in violation of the law.[4,6] The law also prohibits cosmetics from being marketed with unauthorized drug claims, such as treating or preventing disease, or affecting the structure or function of the body.[3] However, the regulatory authority of the FDA is much weaker in regard to cosmetics as opposed to other categories such as drugs and medical devices - cosmetics do not require premarket approval (with the exception of color additives), are not required to undergo specific tests to demonstrate safety of ingredients and are not required to report adverse events associated with the products.[7] The FDA does not have the authority to recall a hazardous cosmetic from the market, however, it can request a federal court for a restraining against the manufacturer or distributor of a violative cosmetic.[7]

The under-regulated cosmetics/personal care products can contain ingredients that include harmful substances that are known to cause endocrine disorders and hepatic toxicity. Without regulation, consumers may not be aware of these harmful products existing in their personal care routine. Many Americans, especially women, are daily consumers of these personal care products. MSS Resolution 36 is calling for action to further define personal care products. In addition, MSS Resolution 36 issues a call for action to promote research of the ingredients in personal care products and their safety to consumers; and, it issues a call to utilize these findings to educate patients about the potentially harmful effects of personal care products.

FDA Regulation of Personal Care Products

The FDA's regulatory authority is very broad and includes foods, drugs, biologics, medical devices, and more.[4] This regulatory authority tends to be closely related to other government agencies since it is very broad.[4] FDA approval means that they have determined that the benefits of the product outweigh the known risks for the product for the intended use of the product.[5] This is usually done if the potential benefit is significant.[5]

The term "personal care product" is not currently defined by federal law and is frequently used to refer to a wide variety of goods[1], including typical cosmetic products and sometimes, personal hygiene products. Laws pertaining to the term "cosmetics," however, include the Federal Food, Drug, and Cosmetic Act of 1938 and the Fair Packaging and Labeling Act of 1967. According to these laws, cosmetics do not require FDA approval. The only relevant stipulation is that the marketing of adulterated or mislabeled products is strictly prohibited.[2] The Federal Food, Drug, and Cosmetic Act defines cosmetics as "articles intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body...for cleansing, beautifying, promoting attractiveness, or altering the appearance."[3] Several related products that require FDA approval, since they are classified as drugs and not cosmetics, include sunscreen, hair restoration products, anti-aging products, and treatments for dry, oily, and irritated skin. As it currently stands, there is no specific definition for "personal care products" within the cosmetic industry or governmental oversight agencies.

The timeliness of this report is echoed in recent governmental proceedings and legislation. In December 2019, the House Energy and Commerce Subcommittee on Health, held a meeting regarding the FDA's inconsistent regulation of cosmetics and personal care products. Legislators discussed the limitations that exist with current state regulations, voluntary registries, and fluctuating budget expansion requests in the FDA's Center for Food Safety and Applied Nutrition (CFSAN) who is largely responsible for cosmetic oversight.[6] The legislation that was introduced last year regarding this topic were "H.R. 4296, the "Safe Cosmetics and Personal Care Products Act" and "H.R. 5279, the "Cosmetic Safety Enhancement Act of 2019". Past legislation that has been introduced is S.1113, a bipartisan bill aimed to amend the Federal Food, Drug, and Cosmetic Act.

This bill would require the FDA to review five ingredients in personal care products a year: lead acetate, formaldehyde, and 3 endocrine disruptors used in shampoo, conditioners, bubble bath, and deodorants. Companies are mandated to report any adverse events concerning these ingredients within 15 days to the FDA. This bill also grants the FDA mandatory recall authority. Under current definitions, shampoos, conditioners, bubble bath, and deodorants would not be able to be cohesively regulated: anti-dandruff shampoos would be considered "drugs," as would clinical-protection deodorants, whilst the rest of the products would be separately considered "cosmetics." In defining personal care products to include the more medication-like versions of cosmetic products, it would be possible to eliminate loopholes in current FDA authority and regulations and pass more all-encompassing bills such as this one.

The FDA's Center for Food Safety and Applied Nutrition (CFSAN) made public an Adverse Event Report System in 2016 to enhance transparency and reporting on adverse events related to food, dietary supplements, and cosmetics. A 2017 JAMA study conducted on the data in this repository found on average, 396 cosmetic-related adverse events were sent to the FDA every year. There was a 78% increase in 2015 and 300% increase in 2016 for adverse events reported relative to the mean across 2004-2016 (time span of repository data). Despite these self-reports, cosmetic manufacturers have no legal obligation to forward adverse events reported to the FDA, so the CFSAN Adverse Event Report System only showcases the events reported by consumers and healthcare professionals.

DISCUSSION

The cosmetic and personal care industry is a lucrative, global enterprise. It is estimated that the organic personal care market, which comprises only one segment of the overall cosmetics market, reached $13.3 billion in 2018. The average woman uses twelve personal care products per day, which exposes her to 168 different chemical ingredients. The average man uses six products, thus exposing himself to 85 unique ingredients[8]. Clearly, proper regulation of these widely pervasive products is important to prevent exposure to ingredients of unknown effect and origin.

Per our review of FDA regulation and research into this industry, we do not believe that research, safety, or regulation would be strengthened by altering the definition of cosmetics to personal care products. The FDA already has a definition for cosmetics which is inclusive of many products applied to the human body. There is no evidence that changing the definition without fully defining the phrase personal care products would affect substantial change.

In regards to the second resolve, it is difficult to specify how research will be conducted without knowing which products and specimens are to be tested and how. Based on our report, we believe that additional consumer safety research on cosmetics should be conducted to protect men and women from the large number of chemicals that they are exposing themselves to daily. However, based on our knowledge of FDA process, research, and oversight, we do not believe that asking the FDA for this research will accomplish the goals of this resolution. While the FDA oversees cosmetic product manufacturing by independent companies and the safety and fidelity of these facilities, the FDA does not do pre-consumer safety research. We believe a better ask for this resolution would be to encourage the FDA to mandate cosmetics manufacturers do their own pre-consumer safety analysis before their product goes to market. This safety analysis would be overseen by the FDA. This is similar to the process for FDA oversight of drugs marketed by independent drug companies. Furthermore, on the post-consumer marketing safety analysis forefront, the AMA-MSS already has pre-existing policy regarding a call for a national registry of ingredients in cosmetics and stronger FDA regulation of cosmetics, including increased recall authority over these products.

Resolves 3-5 ask for current AMA policy to be amended by replacing the term “cosmetics” with “personal care products” where appropriate. While the idea is certainly to apply guidelines to a more comprehensive list of products, this request may actually weaken current AMA policy by being imprecise, given that there is no formal definition for personal care products currently in use by the FDA and the large majority of products that could be classified as “personal care products” already fall under the FDA regulatory definitions of “cosmetics” or “medical devices.”

RECOMMENDATIONS

Your Women in Medicine Committee and Committee on Global and Public Health recommend that MSS Resolution 36 not be adopted.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY AND COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CHIT CEQM Report A
(November 2020)

Introduced by: MSS Committee on Health Information Technology and Committee on Economics and Quality in Medicine

Subject: Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 Interim meeting, the AMA-MSS referred for study MSS Resolution 65, "Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions", which states the following:

> RESOLVED, That our AMA amend policy D-480.969 to read as follows:
>
> D-480.969 – INSURANCE COVERAGE PARITY FOR TELEMEDICINE SERVICE
>
> 1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services <u>and remote patient monitoring services at a comparable rate to the fee schedule set by CMS,</u> and not limit coverage only to services provided by select corporate telemedicine providers.
> 2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies <u>and to achieve adequate reimbursement of remote patient monitoring</u>.
> 3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine <u>and remote patient monitoring are</u> ~~is~~ appropriately defined in each state's medical practice statutes and ~~its~~ <u>their</u> regulation falls under the jurisdiction of the state medical board.

Accordingly, the MSS Governing Council (GC) referred this report to your MSS Committee on Health Information Technologies (CHIT) and Committee of Economics & Quality in Medicine (CEQM). Your CHIT and CEQM ("the authors") examined the definition of remote patient monitoring (RPM) and the distinction between it and telemedicine. Additionally, the authors assessed the cost and challenges associated with both chronic disease treatment and treating patients in rural areas. The authors researched the adoption and outcomes of existing RPM schemes compared to standard practice. The authors also studied the social, logistical, and economic realities concerning the use of RPM. Finally, the authors reviewed existing federal, state, private payor, and AMA policy that was relevant to the ask of this resolution and determined the need for more specific policy.

BACKGROUND

Defining Telemedicine and Remote Patient Monitoring

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The Centers for Medicare and Medicaid Services (CMS) recognizes telemedicine, also called telehealth, as a tool, "permitting two-way, real time interactive communication" between a patient and a clinician.[1] This is achieved using "interactive telecommunications" with audio and video at a minimum.[1,2] Telemedicine is a cost-effective service with various state coverage selections under Medicaid, but is broad in scope and takes many forms. Remote patient monitoring (RPM) is a type of telemedicine that is recognized under CMS reimbursement though with a slightly narrower definition. RPM primarily refers to the use of a specific technology to facilitate interactions between a clinician and patient in an interactive fashion. Key tenets of RPM include data collection and interpretation (via tools such as wearable sensors, mobile apps, web portals, and home monitoring devices), treatment planning, and equipment use, particularly related to chronic conditions[3]

Costs and Challenges Associated With Chronic Disease and Rural Healthcare

Remote patient monitoring has the potential to improve two large public health problems: managing chronic illness and increasing access to healthcare in rural areas.[4,5] According to a Milken Institute report, the total costs in the US for direct health care treatment for chronic health conditions totaled $1.1 trillion in 2016. Including indirect costs, defined as lost income and reduced economic productivity, the total costs come to $3.7 trillion, or 19.6 percent of the US GDP.[6] 5% of people account for 50% of healthcare spending in the US, largely due to managing multiple chronic conditions. Healthcare costs for an individual with 1-2 chronic conditions are about $10,000 annually and $45,000 annually for those with five or more chronic illnesses. The number of people in the US with 3 or more chronic diseases is projected to grow to 83 million by 2030, up from 31 million in 2015.[7] The government has recognized the need to address the growing cost of treating chronic illness by passing the Chronic Disease Management Act of 2018, which began allowing HSA eligible high deductible health plans to cover chronic disease prevention on a pre-deductible basis.[8]

Health care shortages are prevalent throughout rural America. According to a 2017 North Caroline Rural Health Research and Policy Analysis, both rural and urban areas experienced a decrease in all-cause mortality rates between 1999 and 2015 though this decline was more significant in urban areas, leaving rural areas with a higher age-adjusted mortality than comparable populations in urban areas. Rural areas experience higher rates of obesity and overweight people than the nation as a whole, yet many of these areas lack the resources to address this issue. When considering chronic disease management, rural areas are less likely to have nutritionists, dietitians and weight management experts. Reliable transport can be a barrier for rural residents due to long distances and limited availability of public transportation.[9] Remote patient monitoring has been identified as an opportunity to improve the management of chronic conditions in both rural and non-rural areas. However, this opportunity is even more promising in rural areas.

Efficacy and Adoption of Remote Patient Monitoring

Telehealth interventions, as an extension of RPM, have been shown to lower cost of care, as well as help produce better health outcomes compared to standard care.[10] RPM, specifically, has also been shown to decrease overall costs in a healthcare system by reducing the percentage of hospitalizations, emergency room visits, and the average number of bed days of care.[11] Current applications of RPM include the observation and management of cardiac conditions, diabetes, dermatologic changes, Parkinson disease, and falls[12]. Given its early promise in these and other areas, RPM is moving towards broad adoption. 88% of providers have already invested or plan to invest in RPM[13]. The American Heart Association acknowledges both the financial and health benefits of RPM, including for monitoring

hypertension, heart failure, atrial fibrillation[14]. UCLA Health currently offers RPM programs[15]. Additionally, the US Department of Veterans Affairs has been investing in telehealth programs for years, including RPM[16,17]. Finally, RPM provides a means to maintain high quality medical care when in-person monitoring is not possible, as illustrated by Mount Sinai's adoption of RPM through the current COVID-19 pandemic[18]. However, some studies are inconclusive[19]. While many studies show improved patient health outcomes and reduced healthcare costs, RPM depends primarily on patient data, and is therefore reliant on patient compliance and motivation[20,21]. As such, continued research efforts are underway to further elucidate the effects of RPM on patients' health and outcomes.

Challenges of Remote Patient Monitoring

RPM poses multiple challenges for patients, providers, and other stakeholders. Challenges for patients center around usability, perceived usefulness, and troubleshooting support. The initial adoption of an RPM system can be relatively straightforward. However, maintenance of monitoring devices and addressing technical issues can require significant use of time and resources for both the patient and provider, which can discourage continued usage[22]. Patient motivation is also a major factor in effective RPM. For example, stigma related to visible sensors or monitors is a concern for many patients[23,24]. Additionally, many patients have inconsistent access to broadband internet, which could hinder its promise as a care extending tool, or even widen health disparities between urban and rural area[25]. Finally, many patients are concerned with the security of their health data. Healthcare institutions are already being targeted in cyber-attacks for valuable personal health information. Wide adoption of RPM would result in an increase in the number and size of databases holding sensitive informaion, which could increase the vulnerability of personal health data[26,27].

For healthcare providers, the challenges include many of the same technical issues that patients face, but also include reimbursement, incorporation into workflow, legal issues, and clinical issues. Adding RPM to the workflow of a typical practice can be difficult and physicians are concerned about the time needed to learn and manage an additional system. Liability concerns will need to be addressed through the establishment of legal precedents, as well as interstate regulations regarding device standards and appropriate use. Clinical concerns include the effect on the physician-provider relationship and potential fragmentation of care between multiple devices and monitoring teams. Despite the efficacy of a single RPM system, a patient being monitored by multiple devices and providers could result in unsuccessful or poor outcomes[28,29]. Regardless of the extent to which a physician or health system can reimburse for RPM, there are a multitude of concerns and barriers that slow its wider adoption.

Reimbursement of Remote Patient Monitoring

In 2009, CPT codes and guidelines were published by CMS which covered one of the first RPM schemes, wearable mobile cardiac telemetry monitoring. There are two billable components to this service. The technical component covers the necessary equipment and its maintenance, patient set-up and instruction, transmission of data, analysis by a nonphysician, chart documentation and reporting. The professional component includes review and interpretation by a physician and 24-hour availability to respond to a cardiac event. Additionally, there are minimum criteria, specific to ECG monitoring, that a device must meet. However, these codes are limited to 30 consecutive days of monitoring[30].

In 2018, our AMA added three new CPT codes related to RPM. The new codes were adopted into the 2019 Medicare Physician Fee schedule. The addition of these services added to the current services covered by, CPT 99091 which has been in use for more than a decade[31]. (Codes already in use include CPT 99453, 99454, 99457, 99091)

CPT Code	Description of Service	Average Medicare Reimbursement
99453*	Work associated with onboarding a new patient onto a RPM service, setting up the equipment and educating the patient on using the equipment.	$19.46
99454*	Device(s) supplied for recording RPM	$64.15 (can be billed every 30 days)
99457*	Dedicated clinical staff time toward monitoring and interactive communication which includes phone, text and email.	$51.54 (non-facility) and $32.44 (facility).
99091	Dedicated professional time toward monitoring services. Does not require interactive communication like 99457 to bill; however, requires a physician or other QHP to perform these services.	$58.38 (requires 30 minutes of time every 30 days to bill; 99457 and 99091 cannot be billed concurrently)

*** Adopted in 2019[31]**

While all 50 states have policies addressing reimbursement for telemedicine, and parity between it and its in-person equivalents, only 22 states have language regarding reimbursement for RPM[32]. Among those states, some only cover it under larger home health programs, and diseases eligible to be covered vary considerably. Furthermore, these laws often require patients to have a certain number of emergency department visits or hospitalizations related to a diagnosis before reimbursement is considered. Overall, RPM coverage has been increasing since 2013, but the scope of RPM services remains limited for patients who cannot afford care outside of the inconsistent reimbursement policies outlined above[33].

DISCUSSION

While RPM is frequently considered to be a part of telemedicine or telehealth, it has a distinct definition in CMS, State, and Private Payor policy. Additionally, our AMA has Code of Medical Ethics 1.2.9 addressed RPM by saying:, “Sensing and monitoring devices can benefit patients by allowing physicians and other health care professionals to obtain timely information about the patient’s vital signs or health status without requiring an in-person, face-to-face encounter… Devices that transmit patient information wirelessly to remote receiving stations can offer convenience for both patients and physicians, enhance the efficiency and quality of care, and promote increased access to care”. Similarly, E-1.2.12 specifically outlines the ethical practice of telemedicine. Additionally, H-160.937, H-480.943, H-480.946, H-480.974, H-480.968, H-480.969, D-480.970, D-480.966, D-480.968, and D-480.969 all pertain to telemedicine, and hold more specific policy positions that would not necessarily apply to RPM. The authors believe that there is significant precedent to consider RPM as a distinct service. Therefore, the authors also believe that it is prudent for our AMA to have policy pertaining specifically to RPM.

RPM has an opportunity within medicine to improve the care for patients with chronic disease and/or who live in remote areas. The need to improve care in these contexts is significant and timely. A small minority of patients with multiple chronic conditions make up a markedly disproportionate amount of our country’s healthcare spending. This is in part due to these conditions being poorly controlled. Additionally, the proportion of citizens with multiple chronic conditions is projected to double in the coming decade. There is also a growing disparity between the health of individuals in rural areas compared to that of individuals in more urban areas. This is due in part because of poorer access to medical care and a relative shortage of medical professionals.

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In many cases of early adoption and trials, RPM has been shown to improve outcomes for patients with chronic conditions. Because of these results, the majority of providers either use, or plan to implement, some form of RPM in their practice to better serve their patients. There are various social and logistical hurdles hindering RPM implementation. Perhaps most notably, patients and providers can be intimidated by adding a new technology into their routine and wonder if it is worth the investment and time. On a health systems level, a wider adoption of RPM also means an investment in technical infrastructure to ensure that patients in rural areas, who may stand to benefit the most from these services, have the appropriate access to broadband internet and troubleshooting services. Additionally, proper protocols need to be developed so that the information obtained from an RPM device is acted upon appropriately.

While these personal, technical, and logistical challenges are significant, telemedicine has largely overcome these same challenges and grown markedly over recent years. One explanation for the relatively slower adoption of RPM services is the financial feasibility. Reimbursement for RPM services is highly variable and restrictive, if available at all. The prospect of cost savings relative to standard care has driven adoption to some degree, but not all patients who can benefit from these services currently are. Patients generally have to be suffering from a short list of chronic conditions and those conditions must have a significant history of being poorly controlled. Consequently, it is difficult for a provider to leverage RPM as a preventative measure. Building a standard across states and private payors could encourage RPM adoption and reach patients before their conditions become out of control. Additionally, while newer CPT codes have broadened the language regarding RPM, CMS does not yet provide any guidance on what is considered an applicable PRM device or under what circumstances RPM can be reasonably billed for.

With the goal of decreasing the financial barriers related to RPM and clarifying its acceptable use, the authors believe our AMA should expand its policy on RPM. Aside from CME 1.2.9, there are two policies that mention RPM directly. H-385.919 supports RPM, among other services, in the context of, “pilot projects of innovative payment models”. While this policy may have helped lead to the early adoption of some RPM systems, the authors believe that this policy is not meant to advocate for broader adoption or standardization or reimbursement for RPM. In outlining the principles of the Patient-Centered Medical Home, H-160.919 states that, “It should recognize the value of physician work associated with remote monitoring of clinical data using technology.” While this policy specifies that there is added value in a physician utilizing RPM to treat patients, it does not advocate for any standards or suggest how that value should be quantified. These two policies speak to the opportunity and value of RPM but do not address many of the challenges that inhibit its wider adoption and fail to specify what acceptable use of RPM is.

The authors agree with the spirit of the original resolution and would like to see more policy that supports RPM. However, in examining D-480.969, the authors are not confident that editing this policy is the most effective way to achieve this goal. Specifically, the authors interpret clause one as being quite specific to the nature of telemedicine and its natural, in-person analogue. RPM does not necessarily have such an analogue. As proposed, the resolution asks our AMA to advocate for RPM parity similar to that of telemedicine. However, the question then becomes: what is RPM most comparable to? This is something the authors would like to avoid, as it is largely a unique and diverse category of services. Considering existing AMA policy supporting the value of RPM assisted practice, the authors believe that RPM advocacy should instead focus on what standards should be adopted at the state and federal level, and what guidance should there be regarding appropriate RPM devices and their acceptable use.

RECOMMENDATIONS

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Your Committee on Health Information and Technology (CHIT) and Committee on Economics and Quality in Medicine (CEQM) recommend the following resolve clauses be adopted in lieu of the A-19 MSS Resolution 65 – "Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions," and the remainder of this report be filed.

1. RESOLVED, That our AMA will develop model legislation at the federal level to expand and standardize remote patient monitoring coverage policies.
2. RESOLVED, That our AMA will work with the Federation of State Medical Boards to draft model legislation to ensure remote patient monitoring is defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
3. RESOLVED, That our AMA will work with appropriate stakeholders to provide guidance on which remote patient monitoring devices and software services should be reimbursable and under what circumstances.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS CHIT Report A
(November 2020)

Introduced by: MSS Committee on Health Information Technology

Subject: Incorporation of Machine Learning Technologies into Electronic Health Records

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

With the advent of novel machine learning technologies and their growing role in medicine, not only have commercial EHR companies such as Epic begun to offer integrated machine learning tools to their customers, clinicians and informaticians alike are working towards integrating these tools into electronic health record systems to assist with routine clinical care. However, there are a number of concerns about this emphasis on novel technologies. From biases inherent in some modern machine learning algorithms to an unclear legal landscape the patient data used to train these models, it can be a challenge to fully appreciate the complexities of this issue. As such, the I-20 Governing Council has recommended that the Committee on Health Information Technology generate an informational report on this topic to better inform our members about potential actions and to allow for more relevant policy recommendations in future discussions.

BACKGROUND

Basics of the Integration of Machine Learning Technologies (MLTs) and Electronic Health Records (EHRs)

Despite the breadth of current scientific knowledge, much of the medical management paradigm has remained relatively stagnant for the past few decades. Modern medicine has grown to capture a wide swath of data for each patient in electronic health record (EHR) systems, though current practices leverage little of this collected data to optimally treat patients. While the complexities of diseases at the individual level have made it difficult to utilize EHR data in clinical decision-making, machine learning has been proposed as a potential solution to this problem.[1] Machine learning technologies (MLTs) have led to more accurate diagnostic algorithms, individualized patient treatment and real-time clinical decision support which help to address the “one-treatment-fits-all" approach described above.[2] In addition, MLTs can be used to reduce costs, expand access to specialty care in resource-poor areas, and help mitigate physician burnout by automating routine tasks (e.g., documentation and administrative reporting).[3] Not only is PubMed flooded with hundreds of articles across the medical field showing new uses for machine learning technologies, a number of companies including Google, Amazon and Microsoft have started making commercially available MLTs to predict patient outcomes and solve a myriad of issues in healthcare.[2]

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Considering the leaps that MLTs have made in regards to medicine in the recent past, an obvious question arises: what is the best place to integrate these tools to improve patient outcomes? In order to implement effective personalized and population health tools to positively impact patient outcomes, disparate data sources must be harnessed to discover patient-specific patterns of disease progression and provide real-time decision support in electronic health records (EHR).[1] Currently, most companies offer MLTs which operate outside the EHR system, however, many major EHR vendors have started creating and offering MLTs to their customers.[3] In 2015, Epic, the largest EHR network in the US, began offering their clients machine learning (ML) models.[4] It seems that the incorporation of MLTs into hospital workflow is inevitable, however, our data record infrastructure and data protection legislation lag behind.

Challenges Associated with the Adoption of MLTs amongst Physicians

Although integration of MLTs into the EHR promises to transform the practice of medicine, there are a number of challenges that first must be addressed. Doctors may be reluctant to introduce another tool into their workflow, especially one that may seem like a “black box.” The “black box” paradox makes it difficult for a physician to understand why a particular output is provided by a ML algorithm. It is understandable that it would be difficult to trust the results without having access to the underlying reasoning. While it is difficult to properly display the decision-making process of a machine, understanding and addressing the concerns that doctors have about this technology will be essential for widespread adoption.

Doctors have also expressed resistance to information technology when they perceive it to be infringing upon their autonomy.[5] It is possible that the introduction of ML may run into this issue as well, being seen as both an attempt to replace their jobs as well as a means of dictating their possible options for treatment. To overcome this, care must be taken to ensure that ML algorithms are not presented in a way that is seen as forced or obstructive by clinicians and instead presented as a supplementary tool to enhance their decision making power.

Barriers frequently observed in the adoption of other technologies, such as the initial roll-out of EHRs, may also appear here, especially if these are common across different types of technology. For example, ease of use may prove to be a barrier to adoption. If the user interface is poorly designed, either through making it difficult to run or making it difficult to read the output, doctors may elect to avoid using machine learning. Another barrier to adoption could be clinicians’ familiarity with computers, as a lack of familiarity was found to be a barrier to EHR adoption. Ensuring that the relevant software is easy to use and users (healthcare professionals) are able to operate computers at a heightened degree of familiarity will be necessary for the adoption of MLTs.[6] The human aspect of medicine cannot be forgotten as we work towards incorporating MLTs into the workflow of daily medicine.

DISCUSSION

Prevention of Bias in the development of MLTs

One of the major issues that must be addressed with the development of MLT is the issue of bias in ML algorithms. A number of studies have pointed out the presence of or potential for bias in the development of ML algorithms. Recently, an increasing number of algorithms are being developed using data that have been labeled and processed with the help of the general population; training models on such unverified data has led some prediction algorithms to become biased against certain populations of patients, an effect that is further exacerbated when considering a physician’s own bias when interpreting these results.[7] Algorithms also include bias

due to lack of inclusion of minority populations.[8] Furthermore, these biases can go unchecked by the current quality control benchmarks that are in place for ML algorithms.[9]

Causes of bias in ML algorithms are multifactorial. Clinicians often do not know what variables are needed in order to predict outcomes for complex disease processes. As such, ML algorithms often require a large amount of training data, or patient data containing known outcomes which is 'read' by a machine learning algorithm in order to predict outcomes for other patients. Training data sets need to be on the order of 100,000 data points in order to be accurate and generalizable, however, most biomedical datasets fall short of this by two or three orders of magnitude.[1] Further, ML algorithms are only as accurate as the data on which they are trained. The accuracy of these data can be impacted in a number of ways including how it is entered into the database; for example, blood glucose levels can be captured and entered into an EHR through various pathways which can lead to heterogeneous formatting for this data point across patients.[4] Another avenue for these data to be impacted is through human error; for example, patient records from free clinics (which disproportionately provide care to individuals from lower socioeconomic backgrounds) are more likely to include errors or omissions that were overlooked. Therefore, ML models are less likely to accurately predict outcomes for these patients or disease processes.[10]

In general, EHRs were not designed with the intention of supporting the development of MLTs, however, most ML algorithms are designed using data found in these EHRs. To effectively implement healthcare data analytic processes, standardized electronic medical records with a large number of patients are crucial. In order to do this, various big data challenges must be overcome, including the inadequacy of analyzable clinical data; existence of multiple data standards, structures, types and formats; rapid growth in heterogeneous data; understanding of analysis algorithms for clinical data interpretation, exploration and drawing inference; unavailability of effective open-source tools that combine various approaches to model biological interactions; integration of clinical and analytic systems; interdisciplinary field barriers; high cost; implementation of secure frameworks for data collection, simplification, conversion from raw form to knowledge, management and distribution; automatic cleansing of faulty and error-prone EHRs; correctly identifying prescription medication; and implementing predictive diagnostics.[1]

In order to prevent bias in the development of ML algorithms, a number of recommendations have been proposed. Over-reliance on automation must be avoided. Interdisciplinary approaches and continuous human involvement in the development of these tools along with follow-up studies to ensure meaningful results are important to increase the likelihood that these models are meaningful and ethical and that clinical decision support tools based on these algorithms have beneficial effects.[10] Additionally, it is important to ensure the selection of representative training and testing datasets for new predictive models. In order to do this, key variables such as race/ethnicity, language, and social determinants of health must be captured and included in algorithms when appropriate. All variables should be used thoughtfully, however, so that the algorithms do not perpetuate disparities. It is also important to build and test algorithms in socioeconomically diverse health care systems and to develop feedback loops to monitor and verify output and validity using real data.[10] The consideration of the human aspect of medicine is important not only during the integration of MLTs into day-to-day medical workflow but is equally important in the development of MLTs in order to prevent bias.

Financial and Liability Concerns

While AI is presumed to be completely free of the social and experience-based biases present in humans, these algorithms are perhaps even more susceptible than people to making assumptions if the training data used are biased. There are currently few reliable mechanisms to flag such

biases. “Black box” AI tools that give little rationale for their decisions only complicate the problem – and make it more difficult to assign responsibility to an individual when something goes awry.[11] While there has been little to no case law surrounding ML in medicine due to the nascency of the field, it has been suggested that at the current moment physicians will likely find themselves liable for injury when they follow the advice of an AI that is not used as standard of care.[14] As such, when providers are held legally responsible for negative outcomes that may have been caused by data in their possession, it is imperative that the algorithms used present all the relevant information to allow for optimal decision making.[11] Importantly, it has also been pointed out that as the role of AI in medicine changes, the conditions for liability may change as well, necessitating that attention on liability be maintained. Healthcare professionals should also be aware of how their malpractice insurance covers the use of AI as this can vary widely between specialties and location.[12]

Another concern surrounding integration of ML into EHR is how the use of machine learning technology will be paid for. As machine learning systems will require ongoing maintenance to update algorithms and keep hardware operational, they will likely prove to be an ongoing cost, one that some systems may be unwilling to pay for on their own.[13] This may be more pronounced at urban safety-net hospitals where “the implementation of electronic health records...has required significant dedication of scarce and often fixed resources, IT personnel, infrastructure, and physician time.”[14] It is likely that implementing MLTs into systems with such limited resources will run into the same issues seen in implementing electronic health records. If disregarded, this issue could lead to a new health disparity where a lower socioeconomic status deprives one of treatment that utilizes machine learning technology.

Additional Ethical Considerations

Data collected from human subjects to be used for the purpose of improving clinical, practical or administrative activities are not subject to IRB approval according to the HHS Office for Human Research Protections.[15] Data collected for AI and MLT projects often fall under this “quality improvement” umbrella, and therefore do not require IRB approval or necessitate the obtainment of informed consent by data subjects.[15] Initially, it was thought that the nature of these studies allows them to fall under the exemption criteria because 1) the risk to subjects is minimal, 2) the subjects’ rights and welfare would not be adversely affected, and 3) conducting the research without the waiver is not feasible.[15] However, with increasing awareness regarding the complexity of data privacy issues, the risk to data subjects is being reconsidered. In Europe, for instance, the new European General Data Regulation has enacted stringent requirements regarding data privacy and informed consent for data subjects.[16]

Indeed, in an intensely data-driven era, it has been a challenge to human autonomy and control of data, highlighting issues with our current frameworks for consent. Further, AI and MLT projects usually lack foresight by the data controller into what the data will be used for and what the result of data collection will be, making the feasibility informed consent largely impossible.[17] Researchers and legal experts have been working hard to address these issues by composing new frameworks regarding consent for AI and ML activities. One such framework, referred to as the contextual theory, recognizes that the need for consent is context-based and advocates for a more individualized consent process.[17] However, the details regarding our capacity to feasibly implement such a method is unknown. Most experts agree, however, that consent can be obtained on a spectrum, and that the current method of waiving consent completely or requiring full informed consent, is outdated.

CONCLUSION

Ultimately, real transformation of medical practice may require an entirely new kind of EHR, one that is not simply a digital file folder. All the major EHRs are built on top of database-type architecture that is 20 to 30 years old, Reider observes. “It’s rows and columns of information.” He likens these systems to the software used to record inventory at a brick-and-mortar bookstore: “It would know which books it bought, and it would know which books it sold.” Now envision how Amazon uses algorithms to predict what a customer might buy tomorrow and to anticipate demand. “They’ve engineered their systems so that they can learn in this way, and then they can autonomously take action,” Reider says. Health care needs the same kind of transformative leap.[4] Machine learning has the potential to make that leap happen. By automating tasks and making predictions, it can optimize workflow, improve patient care and create a system that can easily adapt to new challenges. However, we must be aware of the challenges that need to be addressed in order to bring machine learning into medicine. Bias in the development of these algorithms is a very real risk and one that can be easily overlooked if vigilance is lacking. Information security, legal liability, financial costs and a cultural resistance to technological change are also significant barriers to the adoption of machine learning that must be resolved. Through all this complexity, it is important to remember that the reward to be obtained from overcoming these challenges far outweighs the cost involved.

RECOMMENDATION

Your Committee on Health Information Technology recognizes the importance of this research on incorporation of machine learning technologies into EHRs and recommends that the remainder of this report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS CME CHIT Report A
(November 2020)

Introduced by: MSS Committee on Medical Education and Committee on Health Information Technology

Subject: Utilization of Third Party Educational Resources in Undergraduate Medical Education

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

An MSS Governing Council Action Item was submitted regarding the utilization of third-party educational resources in undergraduate medical education (UME). The MSS Governing Council approved the action item and tasked the MSS Committee on Medical Education and Committee on Health Information Technology to bring forward a report at our MSS I-20 meeting which addresses the effectiveness of incorporating third party resources into medical school curriculum, with identification of points in medical education that may be most beneficial and appropriate for incorporation.

BACKGROUND

Types of Third-Party Resources in Medical Education

In recent years, a wide variety of non-institutional third-party educational resources have emerged which offer convenient, customizable, and interactive methods for studying topics emphasized on United States Medical Licensing Examination (USMLE) and/or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) exams. The most popular resources include both online and textbook resources (TABLE 1).

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TABLE 1: Categories and Examples of Popular Third-Party Resources

Mnemonic Based	High-Yield Textbooks	Question Banks	Interactive Test Prep	Study Scheduler	Comprehensive Curriculum with Test Prep
Resources utilizing word or visual mnemonics to aid in retention	*"High yield" summaries of board-relevant information with images, mnemonics and study tips*	*Thousands of board-style questions with corresponding subject reviews*	*Combinations of topic reviews or video lectures, flashcards and board style questions*	*Personalized study schedules depending on exam and time available for study*	*Comprehensive visual learning, board prep, and study resource incorporates different elements from each category for longitudinal use by faculty and students*
SketchyMedical[1]	First Aid[2]	USMLE World[3]	Firecracker[4]	Cram Fighter[5]	Osmosis[6]
Picmonic[7]	USMLE STEP Secrets[8]	Kaplan Test Prep[9]	USMLE-Rx[10]		OnlineMedEd[11]
			Pathoma[12]		Amboss[13]
			Boards & Beyond[14]		

Pressure to Perform on Board Exams

Medical student scores on the USMLE STEP 1 and/or the COMLEX-USA Level 1 exams are the factors most heavily cited by residency program directors when considering applicants to interview.[15] Further, matching into certain residency specialties and to out-of-state programs is significantly associated with higher USMLE STEP 1 and STEP 2 Clinical Knowledge (CK) scores, and otherwise well-achieved students often abandon application plans for certain specialty areas due to concerns a STEP 1 score around the mean will disqualify them from consideration.[16–18] Due to pressures to perform well on USMLE exams, medical students have become increasingly concerned with a disconnect between board-relevant material and what is taught through traditional, institution-created content.[19–23] Thus, students have increasingly relied on resources focusing solely on board-relevant material during either dedicated exam preparation (time intentionally set aside outside of traditional curricular activities) or, in some instances, throughout their pre-clinical and clinical studies.[24–26]

During dedicated exam preparation, a combination of these third-party resources were utilized and viewed as essential resources by almost all surveyed medical students in cohorts across

the country, while very few students used or recommended institution-created content.[17,24,27] In addition to University-scheduled dedicated preparation weeks, students have begun to use and recommend non-institutional third-party resources as primary study modalities during their time in both pre-clinical courses and clinical clerkships.

This trend may also be reflected in a decline in in-person lecture attendance. The most recent Association of American Medical Colleges Year 2 Questionnaire found that in 2019 nearly three in 10 (28.8%) of students reported “almost never” attending lectures (a more than 8 point increase from 2016) with over one-third (37.7%) reporting watching online videos instead of lectures for their medical education on a daily basis (a 21.5 point increase from 2016).[28] The mix of institutional resources (in-person lectures, small group sessions) and third-party resources aligns with modern education methods, which show that medical students prefer a variety of active learning tools that offer multiple modes of information presentation, such as those provided by modern third-party educational resources.[24,29] Regardless of the aim of the students’ studies, they will often alternate between traditional lecture material and interactive online tools or question banks depending on the material being learned.

Effectiveness & Cost

Multiple independent reviews have found that students who study independently of their medical school curriculum have received substantially higher scores than those who only study curriculum-related material, with one study showing this increase to be close to 14 points over colleagues who did not utilize third-party resources.[26,27,30] These results hold true even when controlling for potential confounding covariates such as age, MCAT score and GPA. In this same study, it is shown that nearly every student in the study (271 of 274 respondents) used *UWorld* and *First Aid*, and that nearly all of the students participating in this study (77% of respondents) reported studying for STEP 1 alongside their in-house preclinical courses. Further, the amount of time spent studying for STEP 1 during the schools’ dedicated study periods is not alone significantly associated with improved STEP 1 performance, suggesting that *how* one studies is more important to how much they do.

These studies have shown that problem-based learning increases retention of material, and while most medical schools incorporate some problem-based components in their curricula, medical students have augmented this with the thousands of clinical vignettes in the aforementioned question banks to hone their multistep reasoning. Additionally, the concept of “spaced repetition”, involving retrieval of information at periodic intervals, has also been shown to aid in long-term retention of information and contribute to STEP 1 success, which is the method utilized by third-party resources flashcard programs like *Anki* and *Firecracker*.

Despite established effectiveness of certain study resources (namely *First Aid,* spaced repetition tools and commercially available question banks), many popular newer third-party resources have not yet been the subject of focused comparative analyses. This is striking given the considerable cost expenditure for students. Research conducted with *Osmosis* partner schools in 2019 show that students, on average, use 6-10 commercial resources, costing them almost $1000 in total, to prepare for the USMLE STEP 1 and COMLEX Level 1 exams.[31] In addition, one study found that amongst Osteopathic medical students, who often take both the STEP and COMLEX exams, the average amount spent on taking and preparing for board exams during medical school was $7,499, with $4,129 accounting for board prep materials.[32]

Systematic Implementation into Curricula

The potential utility of early integration of digital learning tools in medical education was highlighted in the International Virtual Medical School Initiative, which proposed an organized plan to integrate digital resources into medical school education.[33] Namely, for each week, a topic of focus with accompanying digital lectures were provided, followed by in-person didactics and case studies. Students reported a significant benefit of utilizing the e-learning material within this “flipped classroom” model of education.

Considering the rapidly-changing landscape of how students are preparing to take the USMLE STEP 1 and COMLEX Level 1 exams, some medical schools in the United States have taken initiative to acknowledge the utility these third-party resources may provide their students. Some schools have elected to eliminate in-person lectures entirely (prior to the pandemic).[34] Some schools, such as Tulane School of Medicine and Medical College of Wisconsin, provide guidance and advice to their students on the “best” third-party resources for their students.[35,36] Other medical schools have paid for some of these third-party resources for their students - for example, Medical College of Wisconsin purchases the *Kaplan* STEP 1 Question Bank and the Texas College of Osteopathic Medicine purchases the *UWorld* STEP 1 Question Bank for students - while maintaining their in-house curriculum. Even further, schools including the University of Vermont, University of Michigan, UCLA, and the University of Arizona have integrated digital learning tools (*Osmosis*) in the form of a “flipped classroom” model, where lectures are given outside the classroom through online modems.[31] Similarly, a select few schools have created entire curricula revolving around the use of third-party resources, like Lake Erie College of Osteopathic Medicine’s Directed Study Program, which is a near entirely online program offered alongside their traditional curriculum.[37] These methods have been reported to have shown educators where gaps in knowledge exist in students, as they allow for more interactive in-person discussion of pre-reviewed material. Despite these efforts, there is not yet substantial peer-reviewed literature on the outcome of these systematically-implemented programs in terms of STEP 1 score, residency match, or clinical proficiency.

It is important to recognize the impact COVID-19 has had on digital medical education and third-party resource usage. At the beginning of the pandemic, many schools shifted curriculum to virtual learning for students at all levels as they were removed from the clinical environment, presenting a unique challenge for many institutions.[38] As a result, organizations such as the Association of American Medical Colleges (AAMC) have curated collections of peer-reviewed virtual learning modules that may be used for self-directed study.[39] With respect to subscription based third-party resources, information about what specific schools are doing during this disruption will likely become more clear retrospectively, as presently most decisions are being made internally. However, some schools have provided subscription based funding for students, such as purchasing new subscriptions for *UWorld*. It is unclear however, whether schools are providing this funding because of a desire to systematically integrate these third-party resources into medical education or as compensation for exam scheduling difficulties as a result of closures at Prometric testing centers, where the STEP exams are usually administered.

Current Policy

To this date, no AMA policy exists addressing the widespread popularity of emerging third-party exam preparation materials and the impact on medical education. Existing policy focuses on administration methods (D-275.958 & H-275.962), scoring (H-275.953), regulation (D-295.939), and professional impact (H-255.980 & H-275.958) of the USMLE STEP 1 exam. Beyond establishing broad support for design and ongoing evaluation of curricula that provides a broad education and considers societal needs (H-295.995), the AMA has policy addressing the study and implementation of simulation in medical education (D-295.330), an entirely separate issue

but one with similar fundamental concerns. Further, the MSS passed policy on this issue at I-19, supporting augmentation of traditional curricula with these resources as well as ongoing study on innovative methods for continuing to do so (295.204MSS).

DISCUSSION

For some time, the USMLE and/or COMLEX-USA board exams have represented a pivotal point in the studies of the American medical student. Board scores are one of the primary determinants of a student's trajectory in medicine, with high scores allowing students to better find interviews and acceptances at high-tier and competitive residency programs, while lower scores will often definitively close doors to those students.[40] As a result, the board preparation market has grown exponentially in the past several years, adding new players such as *Osmosis, Picmonic, Firecracker*, and *SketchyMedical* to an already-brimming third-party catalogue of other prominent study resources such as *UWorld, USMLE-Rx, Kaplan, First Aid for the USMLE STEP 1, Pathoma*, and others.[41] As medical students work to achieve the highest scores possible on their board exams, namely USMLE STEP 1 and COMLEX Level 1, students will often purchase these resources outside of their school's curriculum (often with their own finances) in hopes of obtaining higher board scores. Of note, in January of 2022, the STEP 1 exam will transition from reporting numerical scores to a "Pass/Fail" system.[42] While the effects this may have on utilization of third-party resources are purely speculative, it is not unreasonable to predict they will remain popular amongst students given their ease of access, ongoing use in pre-clinical courses and potential for shifting of focus to STEP 2 exam scores (for which a wide array of similar resources are available). On the other hand, free from obsession with a "target" STEP 1 score, students may feel less pressured to spend extravagantly on numerous resources, instead focusing more on institution-created content they may have previously considered "low-yield" for standardized exam purposes.

There is evidence to suggest that select third-party STEP 1 resources (namely *First Aid* and commercial question banks) have a direct impact on improved STEP 1 scores, and this impact may even extend to medical student clerkship performance, albeit with a more unclear link.[43] The impact of third-party resources on improving residency performance is even more unclear. In addition, there is currently a paucity of evidence to suggest the superiority of one resource over another. Despite this lack of evidence, there appears to be tremendous diversity in the specific third-party resources chosen for implementation in medical schools across the country. These findings have several implications. As important as it may be to design educational experiences that are conducive to student goals and preferences, it is critical to consider these things in the context of what has been proven to generate better physicians. The solution of aligning schools' preclinical curricula with students' self-directed, third-party resource-based co-curricula must be balanced against the consideration that STEP 1 has not been shown to be an incredibly meaningful marker of trainee quality and clinical competence. Still, in an age of increasing medical school tuition and medical student debt, medical students spend thousands of dollars to eschew the curricula they pay for. As further highlighted during the pandemic, this represents real opportunity cost for students and educators alike, particularly as students lose time for research, shadowing, and extracurricular engagement with medicine (all of which also contribute to competitiveness for residency programs).

Studies reporting that in-person lectures are declining in popularity places more focus on the nature of the online experience.[33,44] With cancellation of both in person clinical and lecture-based learning due to COVID-19, it can be suggested that utilization of these third-party resources may be useful in adjusting to the change in the academic landscape. While virtually-

hosted lectures and online-learning tools are steadily becoming the “new normal,” it is important to analyze how this may be a possible avenue by which medical educators would be able to integrate these resources into medical education. Given the benefit of digital learning tools, a powerful possible route for integration would be a e-lecture series hosted on a third party platform followed by didactic and question based learning in-person groups. It is clear that online lecture-style resources are appealing to students, exemplified by *Boards and Beyond* and *Pathoma*, because the format of a single lecturer lends significant cohesiveness as the courses logically build on concepts. Given recent events, it has become more important that institutions are transparent about steps taken to augment their traditional curricula with online resources.

Although third-party resource use may be beneficial to student performance on standardized exams, there are limited examples of systematic implementation into curricula. Of note, some medical schools have embraced the advent of such resources and have funded select resources for their students. There are medical schools that have discovered avenues to implement third-party resources into their preclinical organ blocks, allowing for students to study standardized material throughout the school constructed curriculum. However, there are still some educators that endorse lack of understanding of student motivation for utilizing these commercial resources.[45] Further, there remains a hesitation from some medical school curriculum directors over possible pitfalls of “teaching to the test” and the potential ramifications of narrowing studies to solely subject matters on standardized exams.[17,19,27] Due to the specific concepts that may be test material for the STEP 1 exam, this concern may be warranted, as it may be possible that such study methods hinder understanding of fundamental concepts across the preclinical curriculum. As such, further study should be performed not only to further understand the individual learning preferences of students, but to determine if there is a detrimental effect to a focused curriculum of this extent.

In discussion of the feasibility of implementation of the third-party resources into medical school curriculum, given these resources are primarily subscription-based, cost is a substantial consideration. Medical schools must determine if they are willing to foot the bill for class-wide implementation of third-party resources, and, if not, the ramifications of passing this burden down onto their students. These include inequitable access for all students and a need to revise curricula for those students that are unable to purchase the resources. Indeed, many of these resources offer institutional pricing to schools that request them. Further, some (such as *Osmosis)* further partner with institutions to incorporate individual curriculum goals and professional objectives into students’ learning plans.[6]

These differing perspectives bring medical schools to a crossroads: they may choose to integrate third-party resources into curricula, but if doing so must decide to what extent they should augment or replace their own material. In order to determine this, based on the findings in this report, several factors may be considered. First, which resources are currently in use by faculty and students alike and through which medium are these resources being used. Second, how will the institution in question implement the content. Third, in considering the matter from a financial standpoint, how could the school quantify the purchase of the third-party resources in terms of a return on investment, either financially or in tangible benefit to student outcomes. Unfortunately, it is difficult to predict the overarching outcomes of third-party resource implementation into curriculum in light of the unknowns that still remain. In order to understand potential outcomes, however, institutions may engage in internal processes to consider potential benefits of moving ahead with implementation. The medical school can consider communicating with other regional institutions that utilize these resources to understand their outcomes. The school may also conduct “pilot trials” aimed at a focused implementation of a certain resource to

test its efficacy before adopting the resource on a school-wide basis.[46] Finally, engagement with a third-party resource parent company may yield financial incentives, insight on previous instances the resource was successfully implemented and ability to customize platform content to institutional learning objectives. While these are avenues for institutions to consider, they are by no means comprehensive and each respective school should tailor the process depending on the unique needs and perspectives of their own faculty and students. In addition, in order to further elucidate best practices, it is critical that institutions are transparent about their efforts, including with respect to their financial relationships with chosen companies. At the very least, should institutions choose not to rely on these resources, by understanding the qualities that make them attractive to students, they may become better equipped to modernize their own curricula and teaching methods.

Given these findings and the identified gaps in current policy, we believe that future policy and other advocacy efforts may be undertaken to accomplish the following objectives:

1. Encouraging appropriate stakeholders to continuously and systematically study the utilization of non-institutional, third-party resources and efforts made on incorporation into institutional curricula
2. Encouraging institutions and organizations to be appropriately transparent about their relationship with third-party resource parent companies, including both financial and educational motives for partnering with specific companies
3. Raising awareness on benefits, shortcomings and best practices for utilization of these resources, including through augmentation of traditional curricula, as this information becomes available

CONCLUSION

The popularity of third-party resources among medical students has shown no signs of slowing, due to both the historic importance of board scores as a factor is residency admissions and students' preferred utilization of multi-modal strategies. As schools across the country begin to implement these resources at higher rates, an avenue to deliver an individualized learning experience best suited to each student emerges. Although there are important barriers to consider, such as cost of implementation and educator concern with teaching solely to a standardized test, utilization of third-party resources remains an important opportunity for educators to collect insight about their students' learning preferences and use such insight to modernize curricula accordingly. The evidence on precisely which resources are superior or the best practices for implementation is not definitive, but we may still be able to offer recommendations on the most effective way to determine a medical school's individual response. Due to the relatively recent emergence of these resources and the lack of strong longitudinal studies on their efficacy, future attention should focus on determining long term outcomes of third-party integration into medical school curricula. We believe that useful information on third-party resource utilization may be obtained by encouraging schools to internally study learning preferences within their student bodies and recording findings from their own attempts to incorporate these resources. Through their insights, their fellow medical schools will be able to tailor their own personalized means of integration. An alternative route to collect data may be through working with the AAMC to study utilization on a nationwide scale, perhaps through incorporation of this topic in the biennial Y2 Questionnaire. Given the lack of AMA policy on this matter, we offer potential language that may be incorporated into future policy or used to guide advocacy efforts.

RECOMMENDATIONS

Your Committee on Medical Education and Committee on Health Information Technology recognizes this research on Third-Party resources and recommends that the remainder of this report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND MINORITY ISSUES COMMITTEE

MSS CME MIC Report A
(November 2020)

Introduced by: MSS Committee on Medical Education and Minority Issues Committee

Subject: Support for Standardized Interpreter Training for Medical Schools

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, MSS Resolution 48 asked the AMA to work with the American Association of Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) to develop a training module for appropriate interpreter use and furthermore to make available to medical students. The I-19 Reference Committee referred MSS Resolution 48 for report. The Reference Committee specifically stated concerns over:

1) Lack of research concerning interpreter-use training and clinical outcomes
2) The role of the AMA in developing educational modules, specifically as a directing force

Both the Reference Committee and Assembly agreed that this is an important resolution, but could benefit from an in-depth review through a report.

BACKGROUND

Populations that use interpreters

Language barriers effectively diminish both quality and access to healthcare services.[1–3] According to one study that looked at adverse patient outcomes, patients with limited English proficiency (LEP) experienced adverse events at a rate of 49.1% compared to a rate of 29.5% for patients who were proficient.[4] This study, and various others, demonstrate the inadequacy of healthcare delivery to patients with LEP, including patients with sensory impairments. Use of standardized interpreters in medicine has become more widespread as evidence mounts showing improved outcomes and reduced readmissions with their use.[5]

A review of the current literature demonstrates use of standardized interpreters to be most common among the specialties of emergency medicine, family medicine, internal medicine, pediatrics and other healthcare professionals working in primary care.[6,7] Additionally, the use of standardized interpreters is crucial to the practice of psychiatry.[8]

Among members of the medical community, it is widely accepted that physicians have an ethical obligation to treat all patients equitably according to standard of care practices in their respective fields. However, due to language barriers and patients with LEP, this obligation is oftentimes not fulfilled. Despite this widely accepted sentiment, providers consistently underutilize professional interpreters even when readily available.[9]

Multiple studies have demonstrated how the use of untrained interpreters adversely affects patient safety and satisfaction. Ad hoc interpreters refer to any non-professionally trained

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individual providing interpreter services and can include health care professionals, but more commonly includes individuals close to the patient, including family members or children. Without adequate training, ad hoc interpreters commit various errors in medical translation. These errors include omissions, embellishments, paraphrasing and even the use of false cognates.[1] Although errors in medical interpretation are not uncommon, translation errors made by ad hoc interpreters are more likely to result in clinical consequences than errors made by professionally trained medical interpreters.[10] Ad hoc interpreters have also been shown to engage in "false fluency", where substandard interpretation skills leads to inadequate translation, thereby compromising the integrity of the patient-provider interaction.[1]

Given these inadequacies, it is clear that the use of substandard interpreters greatly diminishes the quality and efficacy of healthcare delivery to patients with LEP, many of whom experience additional barriers to healthcare access.[11] Because patients with LEP have the legal right to access health care in their preferred language, health care systems should provide appropriate language services to their patients. In order to ensure that these services are both accurate and efficacious, standardization must be employed.

Consequences of improper interpreter use

In examining the use of interpreters for patients with LEP, two general situations of misuse arise: 1) underuse of professional interpreters when they are available and 2) misuse of ad hoc interpreters, both of which result in increased rates of adverse events. Yawman et al. (2006) found that underuse of interpreters is common among 4th year medical students and residents in a wide array of specialties, including emergency medicine, family medicine, internal medicine, and pediatrics. In their study, 53% of the survey respondents with less than conversational Spanish language skills reported conducting a medical interview on a Spanish-speaking patient without the use of an interpreter. When interpreters were used, professionally-trained interpreters were used less frequently than ad hoc interpreters (42% versus 58%).[12] Another study, conducted by Diamond et al. (2009), found similar results, stating that there is broad underuse of professional interpreters by internal medicine residents, even in hospitals with excellent interpreter services.[13]

Given the underuse and misuse of both professional and ad hoc interpreters in encounters with LEP patients, it is appropriate to discuss the effect of this underuse/misuse on clinical outcomes for patients with LEP. In studying six Joint Commission accredited hospitals in the USA, Divi et al. (2007) found that patients with LEP are 19.6% more likely to experience an adverse event that resulted in patient harm. Additionally, when compared to adverse events for English-speaking patients, the events for limited English proficiency patients were more likely to be related to communication errors (52.4% vs 35.9%).[4] Many other studies have examined the scope of these communication errors. Flores et al. (2003) examined errors made in pediatric encounters with limited English proficiency patients. On average, 31 errors were made per encounter, with the most common error being omission of data (52% of errors). This study included encounters with both professional interpreters and ad hoc interpreters. When comparing errors between the two groups, errors made by ad hoc interpreters were 24% more likely to be errors of clinical consequence (77% vs 53%), for example omitting questions about drug allergies.[10]

Effectiveness of interpreter-use training

Providing standardized training to healthcare providers on the role of interpreters in patient interactions has shown to have an impact on these services' usage. In one study conducted with primary care providers associated with University of California San Francisco, having prior training with regards to the use of interpreters did not necessarily impact their use frequency in the past 2 weeks; however, the trained clinicians in a primary ambulatory setting were more

likely to use professional interpreters than those clinicians that were untrained (78% vs 53%). Furthermore, when comparing those same providers to their resident counterparts, faculty clinicians reported more frequent utilization of interpreters (mean of 4.0 vs 2.5 instances over 2-week span). Interestingly, these faculty clinicians were more likely to have received formal training regarding interpreter use at some point than residents, who undergo numerous trainings and education components within their residency programs. Access to interpreter services training was also demonstrated to impact overall patient interactions, with faculty clinicians reporting less time allotted for each visit (15-minute visits vs 30-minute visits).[14]

While this study demonstrated how training among practicing primary care providers may impact interpreter service usages and aspects of patient interactions, it does not discuss how training would impact medical students' education and skills. In a study on the impact of interpreter training on interpreter utilization skills, third-year medical students underwent training consisting of a PowerPoint-based lesson on how to work best with an in-person interpreter within a free health clinic. Compared to a control group who did not receive training, the trained group demonstrated higher performance scores in measures such as asking one question at a time to limited-English patients (65% vs 31% excellent scoring), listening to the interpreter without unnecessary pauses (80% vs 50% excellent scoring), and speaking in short, simple sentences (65% vs 36% excellent scoring).[15] Thus, providing training on interpreter services to medical students had an impact in their interview skills and ability to effectively utilize these services.

In considering the drawbacks of medical interpreters, the cost of different interpreter services can be considerable, ranging from $45-$150/hour for in-person interpreters, to $1.25-$3.00/minute for telephone interpreters, and $1.95-$3.49/minute for video remote interpreting. The estimated cost of providing interpreter services was $279 per person per year.[16,17] For medical students and providers, learning how to use these services effectively and how to be more time-efficient during patient interaction through an interpreter can save costs by minimizing the amount of time needed for each encounter.

A Boston University quality improvement initiative encouraged providers to introduce, streamline and standardize a process for incorporating interpreters on all morning rounds as needed for LEP families. The major limitation to their process was the constantly rotating residents/medical students as well as the need to train new teams.[18] Ideally, such an initiative could be implemented without such limitations if medical students received standardized interpreter training in place before beginning clerkships. Even implementing a workshop facilitating student-interpreter interactions in a clinical setting could provide additional instruction for students. A study with 152 medical students at UCLA concluded that this workshop closed a gap in their preclinical curriculum.[19] The effect of standardizing interpreter training can be easily evaluated using standardized patient (SP) encounters that are already in place at medical schools, with feedback offered on how students manage the encounter while still keeping the interaction patient-centered.

As mentioned above, it is clear that both medical students and residents underuse interpreters, even when they are available, such as in large hospitals with excellent professional interpreter services. The study by Mazori et al. showed that training has an effect on skilled use of interpreters by medical students, resulting in increasing performance scores.[15] An additional study performed by McEvoy et al. (2009) assessing the effect of interpreter training for medical students also showed that training resulted in improvements in student-self reported efficacy in interpreter use. In this study, 77% of students reported that they felt "more prepared to communicate with a patient with LEP." These results are true for residents and medical students alike.[20] Pediatric residents surveyed from seven different residency programs in a study by

Thompson et al. (2013) reported higher self-efficacy on use of interpreters due to a prior standardized interpreter training.[21]

In the Thompson study, 54% of residents surveyed reported never experiencing any standardized interpreter training.[21] Given that standardized interpreter training is associated with higher reported self-efficacy for medical students and residents, a question is raised of where in the course of medical education this training should be placed. Rodriguez et al. (2011) showed that both skill level and training year were correlated with self-reported preparedness in encounters with limited English proficiency patients.[22] In addition, medical students in the McEvoy et al. (2009) study stated they felt that placing standardized interpreter training at the beginning of third year clerkships was appropriate.[20] In the studies examined, higher-self efficacy was not only associated with training, but also with years of clinical experience. Therefore, the argument could be made that training on interpreter use would be more beneficial and relevant to medical students in phase II (clinical rotations) of the medical curriculum or early in residency. Still, amongst another 29 surveyed schools who offer this form of training, only 28% (8/29) offer it in the third and fourth years of the curriculum.[23]

Current Policy

With regards to the topic of consistent interpreter use and training, the AMA and MSS has not presented any comprehensive policy standards currently. Discussion of payment responsibilities by the institutions rather than by the patient or physician for interpreter services along with advocating legislation regarding insurance coverage do hold policy in the AMA and MSS. Notably, reaffirmed at A-17, policy H-160.924 does request the AMA conduct further research on how the utilization of interpreters- specifically between clinicians that are trained in these services versus clinicians that are untrained- impacts patient care.

DISCUSSION

Interest and research on the utility of standardized interpreters in medicine for patients with LEP has bloomed over the past 8 years, with multiple studies showing improved quality of care and cost savings with reduced hospital readmissions. Resolution 48 identified a gap in AMA policy regarding AMA policy surrounding medical interpreters, as the AMA currently holds no policy on the support of their use. Rather, all current AMA policy regarding interpreters relates to relieving physicians of the burden of payment for their use.

However, the AAMC has published “Guidelines on the Use of Medical Interpreter Services” which accomplishes the asks of the resolved clauses of this resolution which call for the development of a module for appropriate interpreter use. The American Academy of Family Physicians has also authored an article in 2014 titled “Appropriate use of medical interpreters”, which also accomplished the asks of Resolution 48.

On the other hand, with the advent of the AMA Education Hub (EdHub), the AMA has created a series of modules related to Health Disparities and the Health Care Workforce, such as Disparities in Research and Health Equity to Bias in Artificial Intelligence. However, there are no specific modules on Standardized interpreters or their appropriate use. Your Minority Issues Committee and Committee on Medical Education considered that an interactive module could also be appropriate for the AMA EdHub, specifically under the Practice Transformation Topics, where modules on Health Disparities, Health Care Workforce and Health Care Quality exist. If such a module were to be created, it should be designed in a manner that is not redundant to available guidance.

CONCLUSION

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Given that the AAMC has already published guidelines on standardized interpreter use, and that their mission "The AAMC focuses on transforming health care in four primary mission areas: medical education, patient care, medical research, and diversity, inclusion, and equity in health care" we believe they are the institution to best address this issue.[24] We made our recommendations to fill gaps in current AMA policy supporting standardized interpreter use while also avoiding redundancy given that AAMC has already accomplished the original asks for Resolution 48.

RECOMMENDATIONS

Your Committee on Medical Education and Minority Issues Committee recommend that the following recommendations be adopted in lieu of Resolution 48 and the remainder of the report be filed:

1) That our AMA recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments.

2) That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC "Guidelines for Use of Medical Interpreter Services."

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report A
(November 2020)

Introduced by: MSS Committee on Medical Education

Subject: Studying an Application Cap for the National Residency Match Program

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, MSS Resolution 15 asked the AMA-MSS to study the implementation of application limits for the National Resident Matching Program (NRMP) through the Electronic Residency Application Services (ERAS). The I-19 Reference Committee and MSS assembly adopted MSS Resolution 15 and generated a call for a report. The Reference Committee and assembly specifically stated areas of interest covering:

1) Understanding the application numbers in ERAS

2) NRMPs control, or lack thereof, of ERAS

3) The NRMP algorithm for applications and how it works

BACKGROUND

National Resident Matching Program And Electronic Residency Application Service

The National Resident Matching Program (NRMP) Main Residency Match provides a synchronous process for both applicants and program directors to make training selections based on certified rank order lists (ROL), where applicants rank desired programs and program directors rank preferred applicants.[1] Applicants are placed into residency programs by matching through the ROLs. The NRMP uses a mathematical algorithm to match applicants to programs. This is an applicant-proposing process, meaning applicants are matched into programs based on the applicant's ROLs, not the program's. A match is tentative when the applicant's name appears on the list of their highest ranking program. Tentative matches are not binding, because applicants who match early on in the process may be removed to make space for another applicant who ranks higher on the program's ROL.[2] A successful match is binding, meaning that applicants are obligated to accept the matched residency position. If applicants do not match to a program on their list, they have the option to fill an available residency position during the Match Week Supplemental Offer and Acceptance Program (SOAP).[3]

The Electronic Residency Application Service (ERAS) is a centralized service for applying to residency programs. ERAS provides a software platform for applicants to develop and submit their applications and supplemental materials to one or more residency programs. NRMP is a separate organization from American Association of Medical Colleges (AAMC), which runs ERAS. The only interaction between the two is the ability to transfer ROLs from ERAS to NRMP for certification. Both systems are used by all applicants: 4th year allopathic medical students (MD seniors), allopathic medical school graduates (MD graduates), fourth year osteopathic

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students and osteopathic graduates (DO/osteos), U.S. Citizen Student/Graduate of International Medical School (U.S. IMG/IMG), and Non-U.S. Citizen Student/Graduate of International Medical School (Non-U.S. IMG/FMG). In the 2020 match, 37,256 total resident positions (all post-graduate years), were offered and there were 44,959 applicants, 40,084 of which submitted ROLs (active applicants).[4] The total number of applicants has risen each year since the 2004 Match.

Evaluation Of Applicants

Sparse data exists on the utility and practicality of application caps for educational programs. Undergraduate college applications are now largely distributed to over 800 universities through "The Common Application" program. This application limits students to 20 submissions, although some colleges also allow students to apply online or through state-run programs independent of the Common Application.[5]

Allopathic and osteopathic medical school applications in 2019 totaled 896,819 and 193,119 respectively, with an average of 15 applications per student. The number of applications received by medical schools varies tremendously, ranging between 406 and 14,602 applications last year. There is currently no application limit for the allopathic medical school application process, however a cap of 40 applications exists for osteopathic medical schools (only 39 osteopathic schools exist). Allopathic medical school applications are centralized through the AAMC and osteopathic medical school applications are centralized through the American Association of Colleges of Osteopathic Medicine (AACOM)[6,7]

In 2018, medical residency programs received an average of 1,288 applications per program.[8] 48% of these applications were rejected based solely on a standardized screening process and, in 2016, 75% of program directors (PDs) reported using filters or minimum thresholds when selecting residents to interview.[9] For screening criteria, programs have placed an increasing reliance on applicants' examination-related performance.[8] This trend is relatively new, as earlier studies revealed a heavier emphasis on clerkship grades and number of honors grades within top inclusion criteria.[10]

While direct causation remains debated, there appears to be a correlation between a rising number of residency applications and the observed changes to application evaluation and selection practices. Recently, receiving a large volume of applicants was cited as a "top 3 pain point" in the residency application process for over half of programs nationwide.[9] Additionally, 92% of Internal Medicine (IM) PD's indicated an increase in applications to their programs over the last three years.[10] In response, a majority of programs have adjusted their recruitment practices. Up to 66% of programs have begun inviting more applicants and up to 54% of programs have raised the bar for granting interview invitations. Other cited changes were the addition of more interview days or the rejection of applicants without ties to that respective program. Notably, due to this increase in applicants, 46% of IM programs have reported they are less likely to perform a "holistic" review of applicants.[10,11]

Preliminary recommendations from the 2019 Invitational Conference on USMLE Scoring (InCUS) Report included, among others, a potential cap limit on the number of program applications per individual. In theory, by forcing students to be more judicious, residency programs may be afforded more time to thoroughly review applications.[12] Using 13 highly applied-to residencies with 27,027 applicants as of 2013, and assuming an 8-minute application review time per application, an estimated 105,250 hours was spent on application review for these specialties in the 2013 match.[13] A 20 program cap limit would have saved an estimated

33,250 hours during this process for the included specialties. Few nationwide surveys or other studies exist on the popularity of a potential application cap amongst program directors, but the idea has been publicly supported by some prominent program directors.[14] Additionally, amongst studied Internal Medicine Program Directors, an application cap was the most heavily favored potential solution for curbing application inflation.[10]

Still, some program directors or deans have publicly spoken out against the implementation of an application cap, noting that some students may have valid reasons for applying to large numbers of programs, such as those matching as a couple or with family reasons.[15,16] Additional concerns arise over practical challenges, such as limitation adjustments based on specialty or for urban vs. rural areas, and fears that restricting the "Match market" would actually worsen alignment between residents and programs.[17] As such, some specialties have instead advocated for specialty-independent match programs if the ERAS and NRMP were not able to respond to the application inflation.[16] Other PDs have also taken interest in changes that would allow applicants to indicate a high level of interest in a particular program, the creation of a national database of qualities of matched applicants for each program and implementation of a rolling invitation system with nationally set dates and strict deadlines for invitees to respond.[10]

Importantly, some specialties have taken formal initiatives to redesigning the residency application and match process. Among the most notable is the "Right Resident, Right Program, Ready Day One" program spearheaded by the Association of Professors of Gynecology and Obstetrics (APGO) and the Council on Resident Education in Obstetrics and Gynecology (CREOG), which recently received grant funding from the AMA. Over a five-year period, the program aims to develop and implement measures such as an optional early match program, additional metrics of evaluation to contribute to a more holistic review, a national calendar for interviews and a matchmaker service to pair applicants with "best fit" programs.

Application Trends For MDs, DOs, IMGs, FMGs

Between 2002 and 2019, the average length of rank-order list for programs grew from 52.75 to 75.81 applicants. In 2019, the total number of non-couple matching applicants (MD, DO, IMG, FMG) was 36,224 (29,044 matched {80.2%}, 7180 did not match {19.8%}). Of the matched applicants, the average rank list length was 11.22 for those who matched and 4.21 for those who did not match. For US seniors (MD students in the last year of medical school) in the same year, 17,433 applied to the match. Of these, 16,392 matched (94%) and 1,041 did not match (6%). The average rank list was 12.91 for the MD applicants who matched and 6.90 for those who did not match; this information was not provided for DO applicants of the same year.[18]

Historically, and in line with residency programs' rank-order list increase, it has been seen that rank lists of students have also increased dramatically in length over the past two decades. For example, all applicants (MD, DO, IMG, and FMG) who matched in 2002 ranked an average of 7.46 programs, while those who did not match ranked an average of 4.14. Comparatively in 2019, all applicants who matched ranked an average of 11.22 programs while those who did not match ranked an average of 4.21 programs. Interestingly, unmatched US MD students' rank lists have expanded at a high rate (4.62 to 6.90 from 2002 to 2019), there has been a relatively constant rank list length (4.14 to 4.21 from 2002 to 2019) of those who did not match when all students (including DO, IMG, and FMG) are considered.[18]

In 2019, the match rate for MD students (18,925 applicants) was 93.6% while the match rate for DO students (6,001 applicants) was 84.6% and IMG and FMG students (5,080 IMG and 6,869 FMG applicants) was 59% and 58.6%, respectively. It should be noted that, while DO students

are withdrawn from the NRMP following a successful AOA match, these students are not included in the match rate provided by the NRMP as their applications are no longer considered "active".[4] Although information is still being released concerning the recent 2020 match, it has been reported that the match rate for MD students was 93.7% while the match rate for DO students was 90.3%.[19]

In terms of interviews received, US MD students who matched submitted a median of 39 applications and received 17 interviews. US MD students who did not match submitted a median of 59 applications and received 7 interviews. By comparison, all other applicants (DO, IMG, FMG) who matched submitted a median of 78 applications and received 17 interviews, while those who did not match submitted a median of 80 applications and 2 interviews.[4] Further analysis based on speciality can be found in Appendix A.

Costs Of Applying To Residency

Survey data from the last few years reports an average yearly application cost ranging from $1,000-$11,580 per student.[22] This wide range is undoubtedly in part due to students applying to non-primary care specialties, who have on average applied to more programs and, thus, have spent considerably more on fees. These students have also tended to receive less financial support from programs.[23,24] Studies have found that cost is a limiting factor in accepting interviews for up to 70% of applicants.[25]

Using the 2019 median number of applications submitted for matched US seniors (39 applications) and the 2019 NRMP and ERAS cost data, the average cost for an individual applying to residency programs is about $1,328 ($673 on ERAS fees and $655 on NRMP).[26] Given that 44,603 students participated in the 2018-2019 Match, this would equal a total of $59,232,784 spent by residency applicants on just applications alone ($30,017,819 on ERAS fees and $29,214,965 on NRMP fees).[4]

Using the same NRMP and ERAS cost estimates with a theoretically applied application cap of 20, individual application cost becomes $334 ($249 on ERAS fees and $85 on NRMP fees) and the all-applicant total cost dramatically decreases to $14,897,402 ($11,106,147.00 on ERAS fees and $3,791,255. 00 on NRMP fees). A more thorough breakdown of costs can be found in Appendix B.

Of note, the difference in total individual cost between 20 and 39 applications is most apparent with respect to NRMP fees; an applicant saves a total of $570 on NRMP fees compared to $424 on ERAS fees. Still, with the progression of application inflation over the past decade, more significant changes have been observed for the ERAS rate structure. In 2015, applicants paid a base fee of $92 for the first 10 applications, $9 for applications 11-20, $15 for applications 21-30 and $25 for any additional applications thereafter.[27] On the other hand, the NRMP fee for additional applications has remained largely unchanged, with minor rate increases only observed in the initial baseline fee. As a result, an applicant applying to 39 programs would have expected to pay $116 more in ERAS fees but only $20 more in NRMP fees.[28] Thus, as early as 2015, some authors surmised that the tiered pricing system used by ERAS was designed to discourage overzealous applications.[13]

Many studies state that the residency application process is stressful for students, but there is little data directly on the subject of mental wellness during this time. In a survey of 1451 residency applicants during the 2015-2016 cycle who told their top program they had ranked it highly, 70% reported feeling distressed when doing so.[29]

Current Policy

The AMA has two policies largely concerning the match: 1) D-310.974 supports reducing fees, improving transparency, and reporting violations, but does not address holistic reviews or caps; and 2) D-310.977 addresses unfilled programs and unmatched applicants

DISCUSSION

The potential to decrease reliance on standardized exams as screening tools is one major argument for establishing residency caps. Since 2010, the average number of residency applications have been increasing each year. From 2010 to 2015, the average number of applications jumped from 37 to 47 for US medical students and from 97 to 120 for international medical graduates. There is evidence that the rising numbers of applications have pushed program directors to rely more heavily on screening modalities to decrease the number of applications in need of review.[11] Simply decreasing the volume of applications could give program directors time to consider more holistic measures of applicants that take into account personal characteristics and overall fitness into residency programs.

Reducing application burden and minimizing costs for medical students are additional reasons for limiting the number of residency applications per medical student. In 2019, the median number of applications submitted by matched medical students neared 40, and those students received a median of 17 interviews.[4] Interview expenses cost anywhere from $1,000 to $11,580 per student, with a median cost of $4,000. These costs were significantly higher for surgery applicants, 20% of whom spent more than $7,000.[30] Thus, capping the number of residency applications per student has potential to save applicants time and money.

However, due to the limited availability of relevant data, it is not clear how residency application caps would impact educational programs or student match opportunities. While the sheer volume of applications has strained the residency application process, program directors also consistently express difficulty comparing more holistic application information equally across different medical schools. The paucity of reliable measures for evaluating personal applicant characteristics and determining program fitness plays a significant role in the decision to utilize standardized screening tools. With a scarcity in relevant research, it is difficult to predict how an application cap alone would affect these issues.

Large variabilities in the mean number of applications submitted for each specialty must be considered in the determination of a standardized application cap. For instance, the mean individual application number in 2019 for specialties such as dermatology, neurosurgery, urology and orthopedic surgery ranged between 67-80. While the effectiveness of submitting massive application loads for more competitive specialties is not entirely clear, there does appear to be a variability in the "point of diminishing return" between specialties and by STEP 1 scores within specialties.[31] Without clear, evidence-based guidelines, it is difficult to provide thoughtful suggestions for different cap set-points that vary with specialty. Therefore, in fairness to applicants of more competitive specialties, a standardized cap would need to be set at the upper limit of the point of diminishing return across all specialties. However, doing so could offset any potential gains in specialties that have lower mean number of applicants.

Alternatively, if the standardized cap is set too low, we could potentially see an increase in unmatched applicants, especially within highly competitive specialties. Likewise, ultra-high-tier residency programs could see a precipitous drop in number and quality of applications if

students choose to apply to lower-tier residency programs in order to increase chances of matching. The potential unintended consequences such as those stated previously cannot be adequately identified, proven, or disproven without proper evidence.

Importantly, although purely speculative, the impact of COVID-19 on the 2020-2021 application cycle may offer important insight into issues related to "application overload." Some PDs have indicated anticipating an increase in application volume during this cycle, which may be a response to applicant anxiety over matching during a year with no visiting rotations or in-person interviews.[32] At the onset of the announcement of changes to the cycle, in order to increase opportunity for holistic application review, some educators further emphasized the idea of an application limit, suggesting that school counselors advise students to "apply smart" by utilizing resources such as NRMP's Charting Outcomes in the Match.[31,33] As of September of 2020, one month prior to the date PDs are able to begin viewing ERAS submissions, there have been no official changes made to limit application numbers.

CONCLUSION

With the recent change in Step 1 scoring and future implementation of residency application changes for the Obstetrics and Gynecology specialty, upcoming data on the outcomes of these changes will further guide discussions on whether the use of application caps can improve the residency application processes. The potential unintended consequences and logistical challenges to a standardized application cap may very well outweigh the potential benefits to programs. There are a myriad of potential changes to this system (an application cap being just ONE that was mentioned) that could do some part to combating the problems with reliance on standardized scores/application inflation. It is unlikely that one single change will solve this problem and all require further study. The AMA has already established a commitment to working with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants. It will remain important for the AMA to continue to sponsor and engage in things like inCUS in pursuit of comprehensive reform. However, it is clear that including ERAS in these discussions will be of importance going forward.

RECOMMENDATIONS

Your Committee on Medical Education presents this informational report for use by the Medical Student Section and recommends this report be filed.

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Appendix A

Specialty Specific Application Data

Urology: Students pursuing a career in Urology during the 2020 match submitted 441 rank lists with a total of 353 matches for an overall success rate of 80% (83% for US seniors). Of the 354 positions offered, only 1 went unfilled. The average applicant submitted 74 applications and attended 13 interviews.[20]

Ophthalmology: During the 2020 application cycle, 703 Ophthalmology applicants applied through the San Francisco Match with a total of 635 submitted rank lists. The average applicant submitted 77 applications. 495 students matched, leaving 140 unmatched for a match rate of 90% in US seniors. Of the 496 positions offered, 1 went unfilled.[21]

The majority of students applying for residency apply through the National Resident Matching Program (NRMP). The following results refer to the 2019 match cycle.[4]

Neurological Surgery: There were 341 applicants, of which 265 were US Seniors, who applied to the 232 Neurological Surgery positions. Of these, 231 students matched (213 US Seniors), leaving 1 unfilled position. Programs who filled all positions ranked an average of 4.8 applicants per position.[4]

Orthopedic Surgery: 830 US Seniors (1037 total) applied to 755 Orthopedic surgery positions. 693 (83%) US Seniors successfully matched. Overall 752 applicants matched leaving 3 programs unfilled.[4]

Obstetrics and Gynecology: Obstetrics and Gynecology offered 1395 first year positions. 1284 US seniors applied out of 2026 applicants in total. Of these, 1049 (82%) US seniors successfully matched. 1392 applicants matched overall, leaving 2 programs unfilled.[4]

Emergency Medicine: Emergency Medicine offered 2488 positions. 1823 of the 3048 applicants were US seniors. 1617 (89%) US Seniors successfully matched. Overall, 2458 applicants matched leaving 33 programs unfilled.

Family Medicine: Family Medicine offered 4107 positions. 1927 of the 6652 applicants were US seniors. 1601 (83%) US Seniors successfully matched. Overall, 3827 applicants matched leaving 115 programs unfilled.[4]

Internal Medicine: Internal Medicine offered 8116 categorical positions. 3966 of the 12,527 applicants were US seniors. 3366 (85%) US Seniors successfully matched. Overall, 7892 applicants matched leaving 60 programs unfilled.[4]

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Appendix B

Breakdown of Application Fees

With regards to costs directly related to ERAS/NRMP fees, the 2019/2020 application costs are listed as follows:

ERAS:
Up to 10 programs per specialty = fee of $99
11-20 = $15 each
21-30 = $19 each
31+ = $26 each
Example: 20 OB/GYN programs [$99.00 + (10 X $15.00)] + 10 Family Medicine programs [$99.00] = $348

NRMP Match Program:
Standard registration for up to 20 programs = $85
Additional programs ranked = $30 per program

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REPORT OF MEDICAL STUDENT SECTION
COMMITTEE ON LEGISLATION & ADVOCACY

MSS COLA Report A
(November 2020)

Introduced by: MSS Committee on Legislation and Advocacy

Subject: Mandatory Reporting of Sexual Misconduct Allegations to Law Enforcement

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2018 Interim meeting, Resolution 43 asked the AMA-MSS to support the requirement of all state medical boards to report sexual misconduct allegations of physicians to the appropriate law enforcement agencies. The I-18 Reference Committee recommended the resolution be referred for report due to: 1) unclear wording of the resolution that could allow for unintended consequences, and 2) feasibility and scope. Staff experts did not comment on this resolution.

The MSS Governing Council asked the 2019-2020 MSS Committee on Legislation & Advocacy (COLA) to report on this issue for the A-20 meeting. After reading this report, the reader should be familiar with the current regulations surrounding mandatory reporting of sexual misconduct by physicians, especially as it applies to competent adults. In addition, this report explores the possible routes to address the rising number of sexual misconduct allegations while the punishments for these reported events are paradoxically falling.

BACKGROUND

In 1991, the American Medical Association's Council on Ethical and Judicial Affairs (CEJA) reviewed the ethical implications of patient-physician sexual and romantic relationships with the following conclusions: 1) sexual and romantic contact is unethical with a current patient; 2) the same with former patients may be unethical; 3) education on this issue should be made standard in training; 4) reporting colleagues is important.[1] Data on sexual misconduct allegations and official discipline is often difficult to find. Aggregated data on complaints against physicians is often available, but more granular data on sexual misconduct allegations and outcomes is more elusive.[2] Many states offer the ability to look up an individual doctor's history, but this is less useful for identifying trends. From 1981 to 1996, 761 physicians across the country were disciplined for sex related offenses, with 147 alone in 1996.[3] More recently, 2,885 physicians were reported for unprofessional conduct, which includes sexual harassment, in the state of California between 2017-2019.[4] 5% of all administrative actions being taken in California during this time were related to sexual harassment. , 2% of 819 complaints brought against physicians in Oregon in 2018 were related to sexual misconduct.[5] In New York, 8% of the 283 final actions taken by the Board for Professional Medical Conduct were related to sexual misconduct.[6]

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In Georgia, a recent investigation by the Atlanta-Journal Constitution found that two-thirds of physicians disciplined for sexual misconduct were permitted to practice again.[7] Nationally, from 1981 to 1996, Dehlendorf et al. found that 216 of 761 of physicians disciplined for sexual offenses were still licensed to practice.[3] In the United States from 2003 to 2013, there were a total of 1039 physicians with sexual misconduct claims. Of these claims, 29.3% of these physicians had their clinical privileges revoked and 70.7% of these physicians still practiced medicine.[8] While these conclusions are limited by the lack of detailed data, especially regarding claim verification, they nonetheless provide an important window into the problem. An analysis of 101 cases found the following associated characteristics for offenders: male physicians, greater than 39 years of age, not board certified, non-academic practice, and examining patients alone.[9]

Recently, there have been critiques that sexual misconduct is not reported and is unpunished by medical boards.[10,11] An Alabama regulator cited the severe physician shortage as a reason why physicians did not receive severe punishment for proven allegations of sexual misconduct.[11] Although the case of Dr. Larry Nassar received national attention, a recent media report has shown the degree to which this issue has been underreported. Nassar's case is important, but it underestimates and misidentifies perpetrators with relation to geography, specialty, gender, race, religion, and training environment.[11]

Consequences of sexual assault and/or abuse by physicians include depression, anger, drug and/or alcohol abuse, trust issues, and post-traumatic symptoms.[9] The issues reported by victims of physician sexual abuse mirror those reported by survivors of other types of sexual violence or assault.[11]

Mandated reporting of victims of sexual abuse is markedly different depending on the context of the victim and perpetrator. Typically, health care providers are responsible for reporting crimes related to sexual abuse to authorities, including nationwide required reporting of crimes against children or minors.[13] In addition, most states have laws for reporting abuse and sexual assault of dependent adults, while there are variable laws requiring reporting of sexual assault of competent adults by a caregiver or authority figure.[13] In contrast, there are limited laws for mandated reporting of crimes of sexual assault of *competent adults.*[13,14]

DISCUSSION

In order to preserve the integrity of the physician-patient relationship, Resolution 43 proposes a solution that will increase cooperation with law enforcement and increase the transparency of the disciplinary process for physicians facing allegations of sexual misconduct. Previously, AMA CEJA attempted to preempt inappropriate relationships with patients due to the power differential between patients and physicians.[1] CEJA did not make a statement for or against mandatory reporting, prompting the draft of Resolution 43. According to the literature, over time the rate of accusations against physicians has increased while the consequences for physicians have decreased.[3,8] It is unclear why this trend has emerged, but it is a failure of the system if the trend is moving in the wrong direction and makes Resolution 43 all the more important.

An important consideration is the legal requirement for mandated reporting of sexual assault claims. A comprehensive media exposé highlighted the lack of oversight and reporting for physician initiated sexual assaults. However, the laws on mandatory reporting apply to all perpetrators regardless of status with respect to a competent victim. Thus, in order to remedy the issue of mandatory reporting, the legal requirements must be put under further scrutiny. The

possibility of false claims arising from increasing reporting requirements has already been addressed by requiring chaperones for sensitive patient examinations.

This issue was addressed by Resolution 243 at the AMA's A-18 national conference presented by the state of Michigan:

> RESOLVED, That our American Medical Association work with the Federation of State Medical Boards to create and encourage state adoption of "model public health code language" that would require all state medical boards to report criminal sexual conduct or predatory sexual behavior to appropriate law enforcement authorities. (Directive to Take Action)

Subsequently, a report by the Reference Committee on this resolution recommended adoption of a substitute resolution H-515.954 Addressing Barriers to Reporting Health Care Provider Sex Crimes which states that:

> "Our AMA will support the efforts and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine."

This policy solves the important issue of licensing, credentialing and practice, but not the issue of reporting. Reporting is not occurring at sites of care because it is not compulsory and consolidation of information by the Federation of State Medical Boards (FSMB) would not address the issue with poor reporting due to a lack of legal requirements in all but 11 states. H-515.954 is an important policy, but it is a separate issue that does not directly provide a solution to a key component of this problem that deserves unique resources and focus. Given the vast scope of practice related to licensing and credentialing, the Federation of State Medical Boards may not be the most appropriate body to address issues relating to drafting mandatory reporting laws for sexual misconduct claims. It is possible that an independent agency will be the best suited to address this problem

With recent reporting in Alabama identifying a regulator willing to overlook these claims and misconduct due to a lack of medical providers it is even more important that we place the risk of legal action on those not reporting these claims. It is paramount that above all else, the safety of patients and the integrity of the patient-physician relationship is preserved.

This regulatory requirement for reporting is under the purview of the AMA and for the following reasons:

1) Mandatory reporting applies to any sexual assault of minors, dependent adults, or competent adults by an authority figure. Healthcare professionals would be included as both "mandatory reporters" and as "authority figures" in this context.
2) Perpetrators of such assault may include healthcare professionals.
3) This requires a valid and objective process to protect sensitive populations from physical and emotional abuse

RECOMMENDATION

Your Medical Student Section Committee on Legislation & Advocacy recommends that the following recommendation is adopted and the remainder of the report is filed:

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RESOLVED, That our AMA-MSS strongly encourages universal mandatory reporting of sexual assault claims when the alleged perpetrator is a health care professional to the appropriate law enforcement agencies.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LONG RANGE PLANNING AND COMMITTEE ON MEDICAL EDUCATION

MSS COLRP CME Report A
(November 2020)

Introduced by: MSS Committee on Long Range Planning and Committee on Medical Education

Subject: Support for Mental Health Absences for Students and Residents

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, MSS Resolution 37 asked the AMA-MSS to support mental health as a valid use of a "sick day" for all medical students. The I-19 Reference Committee recommended that Resolution 37 be referred for report. The MSS Assembly and Reference Committee specifically stated concerns over:

1) The Committee on Medical Education opposed this resolution citing unintended consequences and lack of research on the use of sick days by medical students.
2) Further research may allow the MSS to better understand existing policies and programs and current use of sick leave absences by medical students

Both the Reference Committee and the Assembly agreed that this is an important resolution that may be strengthened through this report. Specifically, we note the feasibility, implementation, and possible outcomes, including advantages and unintended consequences.

BACKGROUND

Burnout is a multifactorial occupational syndrome, characterized by a triad of symptoms involving high levels of emotional exhaustion, depersonalization, or professional cynicism and dissatisfaction with one's professional accomplishments.[1] On average, in the first four years of medical school, 34% of the students exhibit moderate levels of burnout. Lower support, higher stress, and lack of control over one's life are significantly related to burnout.[2]

A significant portion of current interventions in medical schools to address burnout involves making counseling services more readily available and accessible for medical students. At the University of Pittsburgh School of Medicine, they employ an aggressive and proactive approach to ease the transition of medical students to medical school, reduce stress, and address issues of access, privacy and stigma. Students learn of the Pittsburgh Model, which provides mental health care to students at no cost without associated billing to insurance. Treatment notes are stored in a firewall-protected electronic medical record of the university counseling center, separate from the university hospital's electronic medical record.[3] The University of California, San Diego School of Medicine has implemented the Healer Education Assessment and Referral program, which provides students, house staff, faculty, trainees and hospital staff with confidential, online assessments of stress, depression and other related issues. If mental health concern is identified, personalized referrals are made to local mental health clinicians and other community resources.[4] The Keck School of Medicine at University of Southern California began

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hosting "Keck Checks," which are 15-minute health visits for all first-year students. Its goal was to provide a brief mental health screening while reducing barriers to seeking treatment.[5]

Efforts are also being done to alleviate physician burnout. Individual-directed interventions typically include mindfulness techniques, cognitive behavioral therapy, improved communication skills, and stress coping strategies Organization-directed interventions usually involve simple changes in scheduling, reducing workload or even bigger changes such as improving teamwork, changes in professional assessment, monitoring reductions in job demand, increases in job control, and increased participation in decision-making.[6]

However, there is no research specific to medical students' perceptions of or attitudes toward mental health days, indicating the need for more research on this topic. Additionally, there is a lack of research addressing the impact of mental health days or personal days on employee wellbeing in other industries, again indicating the need for more research in this area.

Some research has been completed on employee wellness programs more generally. A 2013 RAND study found that nearly 80% of businesses with ≥50 employees had instituted an workplace wellness program. These programs were found to reduce risk factors for chronic diseases, increase health behaviors, decrease health care costs, and improve productivity.[7] Another study evaluated the effectiveness of an employee wellness program implemented at a large retail company. The authors observed a significant increase in the number of employees engaging in regular exercise and active weight management but saw no changes in other measured factors, which included health, medical spending, and employment outcomes.[8] This may be due to the fact that the study's design prevented selection bias of healthier participants which may inflate the benefits of the workplace wellness program. Additionally, unmeasured variables in this study such as morale, productivity, and teamwork could have been positively impacted by the workplace wellness program.[8]

DISCUSSION

To address medical student wellness, mental health days are noted as part of the solution. A limitation of our study was that schools had differing meanings of, names for, and implementation of mental health days. We defined a mental health day as any time period that a student could request off for personal reasons that do not qualify as an excused absence.

Settling on a definition, we found that medical schools will refer to mental health days differently, including but not limited to Administrative Days (Brody School of Medicine at East Carolina University)[9], Personal Wellness Days (Creighton University School of Medicine), or Personal Health Days (Rutgers New Jersey Medical School).[10] Complicating the matter, the rules regarding the mental health days varied from how much advance notice is needed (range from 24 hours before day to week before start of the affected rotation), to the number of mental health days given, to when they can be utilized (clinicals vs non-clinical). Another school (University of Toledo) has discussed a regular mandatory (half-day a week) mental health day intended to eliminate stigma and allow students to attend weekly therapy without concern of others noticing.

This initiative would have many perceived benefits; the most obvious benefit is empowering students to address their regular mental health needs without compromising their privacy by divulging personal details to clerkship directors or school administrators. Furthermore, mental health days could be a systematic approach to addressing the epidemic of medical student burnout, as students will have the option to utilize these days to alleviate stressors of training and life. Giving students the option to take mental health days returns a level of autonomy in

managing their schedule that is often compromised during medical training. Having mental health days could also combat the decline in empathy seen in medical students during clinical rotations, an outcome students may benefit from throughout their careers.

Additionally, having mental health days may allow students to address matters of personal physical health, such as scheduling doctor's appointments or dental check-ups. Poor physical health can have an adverse effect on mental health; mental health days could be a way to promote personal health and reinforce healthy habits for medical students. Finally, although there is a potential for abuse and schools have evolved their policy for mental health days in response, students are likely to take advantage of these days if there is a true need. The difficulty in developing these days for medical students come from the fact that there is little direct research on how and if these days impact medical student mental health. The vast majority of need assessments and analysis of impact is anecdotal.

CONCLUSION

It is widely known that medical education is stressful and has negative effects on both the mental and behavioral health of students. However it is unlikely that one change in medical education will correct this issue completely. Many different avenues in both medical education and non-medical industry have been implemented with varying rates of success. Specifically, "mental health days" have not been studied to this effect, thus the authors are wary of unintended consequences and are interested in possible benefits.

RECOMMENDATIONS

Your Committees on Long Range Planning and Medical Education recommend that the following recommendations are adopted in lieu of MSS Resolution 37, and the remainder of this report be filed:

1) That our AMA encourage medical schools to accept flexible uses for excused absences from clinical clerkships,

2) That our AMA-MSS reaffirm 295.001MSS.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LONG RANGE PLANNING AND COMMITTEE ON MEDICAL EDUCATION

MSS COLRP CME Report B
(November 2020)

Introduced by: MSS Committee on Long Range Planning and MSS Committee on Medical Education

Subject: Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim meeting, MSS Resolution 53 asked the AMA to collaborate with relevant stakeholders to form a task force designated to explore the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment and furthermore, requested the AMA ask the Accreditation Council for Graduate Medical Education (ACGME) about the need for standardized education on Osteopathic principles and practice among ACGME-accredited faculty to support osteopathic residents. The I-19 Reference Committee and MSS assembly referred MSS Resolution 53 to be studied as a report. The Reference Committee and assembly specifically stated concerns over the:

1) Feasibility of generating such a task force,
2) Method of increasing non-osteopathic physicians exposure to osteopathic practices and principles,
3) Barriers experienced by osteopathic residents during training.

Both the Reference Committee and Assembly agreed that this is an important and timely resolution, but could benefit from a report.

BACKGROUND

The evidence basis for osteopathic manipulative medicine/treatment (OMM/OMT) is quite broad and spans across many disease processes and organ systems. There is also evidence that supports its use as an adjunct treatment in a variety of conditions. For one, there have been demonstrated improvements in symptoms of menopause, perimenopause, and pregnancy by meta-analyses.[1] In a separate meta-analysis, OMT has shown benefits to both chronic low back pain and acute low back pain during the peripartum and postpartum times.[2] Evidence also exists showing benefits in premature neonate, pneumonia, and neck pain populations.[3–5] However, much of the evidence base for other medical conditions is weaker. While some studies have demonstrated irritable bowel syndrome symptom improvement with osteopathic manipulation, those studies were hindered by small sample sizes.[6] Studies on manipulation in neurologic disease also showed promising results, but their results are limited due to flawed study designs.[7] While many techniques have at least

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some supporting evidence, not all of them have such support. Further, for those that do, the evidence vastly ranges from well-supported to supported only by studies with inadequate designs.

In order to train residents in osteopathic practice and principles (OPP) and osteopathic manipulative treatment (OMT), faculty must be available and qualified to train these residents. MSS Resolution 53 asks for the creation of a task force to assess the need for development of graduate medical education faculty in the supervision of OMT. Furthermore, the Resolution asks the AMA to reach out to theACGME regarding whether standardized education in OPP/OMT is necessary for teaching faculty.

Non-osteopathic faculty are unlikely to have any experience with OMT, let alone sufficient expertise to train residents in the practice. This fact is recognized by multiple osteopathic professional organizations and schools, which offer allopathic physicians and international medical graduates a variety of paid training classes and courses to receive education on osteopathic manipulation.[8,9] Unfortunately, there is no evidence to indicate whether or not faculty providing continuing medical education in OMT through such courses could demonstrate efficiency in this skill to be considered appropriate teachers. Notably, the ACGME's Osteopathic Principles Committee (ACGME-OPC), the body which outlines criteria for osteopathic recognition (OR) of graduate medical education programs, requires that program leadership, including a portion of faculty be certified by other professional bodies in order to considered for formal osteopathic recognition.. Those considered as acceptable faculty may include: AOA board-certified physicians; a Doctor of Osteopathy with board certification through an American Board of Medical Specialties; or a Doctor of Medicine graduate of an already recognized program with board certification through an American Board of Medical Specialties.[10] It is therefore reasonable to assume that any graduate medical education program seeking to properly educate residents in osteopathic manipulative medicine would need to recruit faculty to leadership positions with the above qualifications. However, no formal studies have been conducted to evaluate whether programs have adopted such requirements.

Osteopathic Recognition (OR) is a "designation conferred by the ACGME's Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate, through a formal application process, the commitment to teaching and assessing Osteopathic Principles and Practice (OPP) at the graduate medical education level." Programs must meet criteria laid out by that committee and apply for recognition.[10] As of the 2019-2020 academic year there were 226 graduate medical education programs with osteopathic recognition. One additional program offers education in osteopathic principles and practice, but is not yet recognized. An additional 14 programs are applying within this same academic year for official recognition.[11]

There are a number of formal requirements laid out by the ACGME-OPC for OR. Briefly summarized by Miller et al. 2017:

- OR requires that a program create an osteopathic learning environment that spans the length of the educational program. The program may utilize longitudinal and rotational components, focused or integrated rotations, osteopathic rounds, or patient care conferences. Either all the residents or a portion of the residents in a specific track can participate in OR.
- OR requires at least 2 faculty who develop curriculum and promote OPP and the use of osteopathic manipulative treatments. The faculty and designated residents have specific scholarly activity requirements and the residents are evaluated based on designated Osteopathic Principles and Practice Milestones.

- Every program with OR must have an osteopathic-focused track director and the program must maintain an average of at least 1 resident per year of the program. Programs may share osteopathic-focused faculty and track directors.
- Prior to beginning osteopathic-focused residency training in a program with OR, non-DO physician applicants must demonstrate some interest and understanding of OPP either by completing an elective OPP rotation, completing courses at an osteopathic medical school, or having other training or experience to demonstrate entry-level competency.
- Consistent with current policy, residents graduating from an osteopathic-focused program need to take and pass only 1 board certification exam (ABMS or AOA).
- Residents in a recognized program must be assessed for OPP knowledge and "skill proficiency in OMT as applicable to [their] specialty."[12]

It is also important to ask DO residents desire to learn OPP and OMT in ACGME graduate medical programs. AACOM published surveys in 2015 and 2017 indicating that approximately two thirds of osteopathic medical students would think more highly of programs if informed that a program has osteopathic recognition (OR). Half of the students surveyed weigh OR as important or very important, whereas the other half consider it to be of limited importance or no importance.[13] However, there are currently no surveys of resident attitudes regarding learning OPP and OMT in ACGME graduate medical programs. Of the osteopathic residents stating their expectation to use OMT after graduation, the number of practicing DOs actually practicing OMM is less.[14,15]

DISCUSSION

Osteopathic medicine as a whole incorporates various manipulative techniques and holistic principles which can be used in the healthcare setting to help improve patient outcomes. As provided in the background, research demonstrates that OPP and OMT have been shown to be efficacious, however more so in some medical fields than others. With the recent merger into a single ACGME accreditation system, allopathic and osteopathic residency programs are now available for all graduate medical students.

The first resolved clause of MSS Resolution XX called for the establishment of a task force among specific stakeholders to explore the need for GME faculty development in the supervision of OMT. To address the necessity of establishing such a task force it is first important to briefly assess the need for expansion of OMT training capacity. As of the 2019-2020 academic year there are approximately 227 PGY-1 GME programs with osteopathic recognition out of the 4,780 available programs (roughly 5%). During the 2019 match period, osteopathic medical students represented 17% of the filled PGY-1 residency positions. Over 50% of these residents matched into major primary care fields for which OMT has been shown to be beneficial (i.e. Family Medicine, Internal Medicine, and Pediatrics). During the 2020 match period, similar results were seen with 5,968 out of 6,581 graduating osteopathic medical students matching to residency programs, again with a leaning towards primary care fields as 56% of students matched in Family Medicine, Internal Medicine, and Pediatrics.[18,19] Since 2015, the number of U.S. osteopathic medical school students and graduates seeking positions has risen by 3,052, a 103 percent increase and nearly a quarter of all current U.S. medical students are training in osteopathic medicine.[16,17] US osteopathic seniors had a 4.1% unmatched rate in 2020, compared to 4.0% in 2019 and 4.3% in 2018, 2017, and 2016, which shows that match rate has been unaffected by the ACGME merger.[18,19] The discrepancy between the number of recognized GME opportunities in OMM and the increasing number of residents graduating with OMT training suggests there is a need to

address the future level of continuing ACGME osteopathic training available to applicable residency programs.

The second resolved clause requests that the AMA-MSS ask ACGME about the need to standardize education of OPP and OMT among the faculty of residency programs without osteopathic recognition. ACGME currently identifies 233 programs with osteopathic recognition, and is working with programs to increase osteopathic recognition, however this is not a standardized process.[20] Standardizing OPP and OMT education of residency faculty is not feasible to implement across all residency program specialties that do not have osteopathic recognition due to residency training being vastly different in the various medical specialties. Additionally, the data only supports limited use in a subset of specialties and does not support the evidence based use of OMT in every field of medicine. Therefore, expanding and standardizing osteopathic training across all non-recognized residency programs, regardless of specialty, would not be the best use of AMA's time and resources.

Currently, obtaining osteopathic recognition does not provide a standardized method to educate faculty, as requested by this resolution. However, it does require faculty to demonstrate a standardized level of education to qualify the program for osteopathic recognition as distinguished by the ACGME Osteopathic Principles Committee. By independently obtaining osteopathic recognition, an ACGME program proves that the faculty are educated, capable, and committed to continuing a student's osteopathic training. Implementing a requirement for mandated, standardized OPP and OMT education across all residency programs, as suggested, may lead to the development of programs that are not as independently committed to a student's osteopathic training. To address faculty that did not complete an osteopathically recognized ACGME-accredited program (a requirement for the faculty of programs applying for osteopathic recognition), there exists independent CME courses meant to teach physicians OPP and OMT.[8–10] However, it is unlikely that such courses alone would be sufficient or feasible to prepare non-osteopathic faculty to adequately train and supervise osteopathic residents related to OMT principles. While it may be necessary to establish a faculty training process for non-recognized residency programs in the appropriate fields, such a task would be best handled by other entities rather than through the AMA or AMA-MSS. Continued support of osteopathic medicine and proper graduate medical education moving forward would be better suited focusing on more specific issues such as increasing the motivation for programs to independently pursue ACGME accreditation. The establishment of a taskforce meant to assess the need for expanding OMT training will be important in this and will likely uncover the best ways to educate new programs if the need is found.

CONCLUSION

OMT has a varied evidence base and a process for establishing a residency program that instructs osteopathic principles and practice exists and residency programs are utilizing this mechanism. However, there seems to be more graduates interested in continuing osteopathic principles than available positions. The need for standardizing osteopathic education across all residency programs is not well supported, as it is an extremely varied field and itself does not have standardized teaching models.

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RECOMMENDATIONS

Your MSS Committees on Long Range Planning and MSS Committee on Medical Education recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolve clause of MSS Resolution 53 be adopted as amended as follows:

That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs.

2) That the second resolved clause of MSS Resolution 53 not be adopted.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES AND COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS CSI CHIT Report A
(November 2020)

Introduced by:	MSS Committee on Scientific Issues and MSS Committee on Health Information Technology
Subject:	Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
Referred to:	MSS Reference Committee (Sarah Mae Smith, Chair)

INTRODUCTION

At the 2019 MSS Interim Meeting (I-19), the MSS General Assembly passed Resolution 22, entitled "Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices." The resolution aims to address current gaps in the Food and Drug Administration's (FDA) eligibility criteria for approval of novel drugs and medical devices and calls on the FDA to adopt more stringent criteria regarding pre- and post-approval clinical trials, standards of evidence, and reporting requirements. The I-19 Reference Committee subsequently requested that the MSS Committee on Scientific Issues (CSI) and the Committee on Health Information Technology (CHIT) opine on the rationale and feasibility of the resolution's first resolve clause:

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

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of the evidence from clinical trials and/or post-market incident reports prove that the medical device is unsafe and/or ineffective for its labeled indications; and

(g) the FDA should make the annual summary of medical devices approved under expedited programs more readily available to the public and consider adding information on confirmatory clinical trials for such medical devices."

Specifically, the Reference Committee requested that both CSI and CHIT work with the authors of the resolution to further refine the language of the clause, in hopes of better capturing the nuances involved in drug and medical device approval processes.

BACKGROUND

Medical devices are becoming increasingly prevalent in the practice of medicine, growing from an estimated 25 million Americans in the early 2000's having an implanted device to an estimated 32 million Americans in 2019.[1,2] Per the FDA, a medical device is defined as:

> *[A]n instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.*[3]

There are three classes of devices as recognized by the FDA, classified broadly from least potential danger to the patient (class I) to most potential danger (class III).[4] Class I devices are defined as "devices that present minimal potential for harm to the user," and simply need to follow the general regulatory controls for safe use as outlined by the FDA.[5,6] Class I devices do not need to be cleared by the 510(k) process, also known as Premarket Notification (PMN), or receive Premarket Approval (PMA). This category consists of devices that have functions related to human health, and generally consist of relatively benign products like dental floss, bandages, and tongue depressors. Class II devices are those who have higher risk than Class I devices, and are described by the FDA as "devices that generally present a moderate risk of harm to the user," but do not meet the inclusion criteria for Class III.[5,6] These can have additional safety requirements for implementation that are not covered by the general regulatory controls that cover the usage of Class I devices. This includes a wide variety of products, including powered wheelchairs and some laboratory tests. Class III is the most restricted class, containing "devices that sustain or support life, are implanted, or present potential high risk of illness or injury."[6] This category includes devices that are directly implantable, including implantable pacemakers and breast implants. In total, 35% of medical devices currently approved by the FDA for marketing are Class I, 53% are Class II, 9% are Class III, and 3% are currently unclassified.[6]

In the current regulatory model implemented by the FDA, there are three major processes through which devices are approved: Premarket Notification (PMN, the 510(k) approval pathway), Premarket Approval (PMA), and the Humanitarian Device Exception (HDE).[6] PMA is the most stringent process and requires devices to prove their safety and efficacy to the FDA before they are allowed to be marketed in the United States.[7] The PMN process, more broadly known as the

510(k) pathway, is a mechanism by which companies can declare a new device as reasonably similar to a device already approved by the FDA, known as a "predicate" device, and bypass the more rigorous PMA process.[7] Finally, devices that are intended to treat orphan diseases -- diseases that affect no more than 8,000 people in the US per year -- are designated Humanitarian Use Devices (HUDs) and allowed to bypass the PMA through the HDE.[6,7]

The goal of the 510(k) pathway, per the FDA, is to stimulate growth and innovation of new medical devices that are likely safe and efficacious. Their exact reasoning is that "the 510(k) program, as it currently exists, is intended to support FDA's public health mission by meeting two important goals: making available to consumers devices that are safe and effective, and fostering innovation in the medical device industry."[8] Given the high percentage of new devices that get PMN clearance, this seems to be an effective process at increasing device diversity in the market.

The 510(k) pathway to medical device marketing is not without scrutiny. There have been a number of studies into the drawbacks of this policy, mostly focusing on the lack of scientific data backing devices being brought to market.[9] In many cases, there have been devices that took advantage of this pathway that were later shown to be less efficacious than anticipated, and a number of devices that were found to be unsafe in their indicated usage. Some examples of devices that were later found to be less safe than expected include transvaginal meshes, metal-on-metal hip implants, surgical meshes, and bioresorbable vascular scaffolds.[10,11,12,13,14] In the case of the surgical meshes specifically, the authors of that article found that all surgical meshes on the market today were introduced through the 510(k) pathway, and that one only needed to go back three generations of predicate devices, on average, to find a device that has been recalled.[13]

In response to the criticisms of the 510(k) pathway, policy adjustments have been made in recent years. In 2012, the Safety of Untested and New Devices Act (SOUND Device Act) was passed, which prohibited the use of recalled devices as predicate devices, allowed the FDA to reject claims of substantial equivalency (SE) based on recalled devices, and mandated the Secretary of Health and Human Services to maintain a database of acceptable predicate devices for the 510(k) pathway.[15] Additionally, devices that are corrected or recalled need to have a root cause identified by the manufacturer so that other devices that have claimed a similar mechanism of action may be further studied. Despite the attempt to correct the issues that some found in the 510(k) pathway, criticism of this process has persisted.[16,17]

DISCUSSION

Medical devices are increasingly common with one in every 10 Americans having at least one medical device. Indicated for a wide array of conditions or situations, current FDA guidelines provide a clear path for clinical testing, data review and final approval for use in the real-world. However, there is still an opportunity for the AMA and the FDA to make these guidelines even more clear.

Importantly, this resolution makes direct reference to the Medical Device Amendment (MDA) to the Federal Food, Drug, and Cosmetic (FD&C) Act passed in 1976. In addition to creating a three-class, risk-based classification system for all medical devices and providing a regulatory pathway for medical devices to be studied in patients, it also put into place the 510(k) premarket notification program. By demonstrating that a non-approved medical device is "substantially equivalent" to a legally marketed device, even if this device was approved before the implementation of rigorous regulatory requirements in 1976, the FDA considered this to be sufficient evidence that the non-approved medical device was "at least safe and effective." Though this was likely an effective

measure in reducing the regulatory burden for medical devices, this resolution highlights some crucial weaknesses in its function both from an oversight perspective (what does "substantially equivalent" entail) and from a patient safety perspective (does "substantially equivalent" equate to "at least safe and effective"). Further, this Resolution notes a lack of consistent AMA policy on the regulatory review and approval of medical devices in general, not just to the 510(k) program. In reviewing Resolution 22, the Reference Committee noted that resolve sub-clauses A, B, and F are nearly identical to current AMA policy H-100.992 which supports the FDA's review and approval process for drugs or medicinal products. By simply inserting the phrase "…and medical devices" in the appropriate spaces in this policy, these subclauses could be removed and would not need their own document. However, AMA H-100.992 is clearly a contentious policy as it has undergone revision twice in the last two years with multiple amendments and revisions before then. Further, it may provide an opportunity for delegates to debate the policy in its entirety instead of the limited scope of this proposed amendment.

With these statements in mind, the following recommendations are presented concerning amendments to Resolution 22. Given the similarity between subclauses A, B, and F of Resolve clause 1 to existing AMA policy, this committee feels that an amendment to AMA H-100.992 including the phrase "medical device" with all mentions of drug or new drugs is the most effective and comprehensive pathway to improve current AMA policy. If such an amendment is proposed, these subclauses can be removed from resolve clause 1. The remaining subclauses are not included in AMA H-100.992 and are discussed below.

Regarding subclause C and D, this committee feels there is a significant amount of overlap in intention and could be joined together into a single subclause. Further, it is unclear if a regulatory pathway is currently in place for the planning of confirmatory trials at the time of accelerated approval. As such, this new subclause was reworded to support the rapid conduct of confirmatory trials while highlighting the situations of greatest import and, likely, the greatest potential risk to the public.

After thorough discussion and policy review, this committee recommends the elimination of subclause E as it is redundant with current FDA policy. The FDA has published a document titled 'Design Considerations for Pivotal Clinical Investigations for Medical Devices' (https://www.fda.gov/media/87363/download) which provides explicit guidelines for the conduct of confirmatory trials in medical devices, so no further support from the AMA is necessary. Regarding subclause G, additional research noting the poor compliance rate for reporting of adverse events led this committee to recommend a minor amendment to this subclause. This amendment supports the addition of adverse event reports to an annual summary of medical devices to ensure that clinicians are aware of the risks of new devices and to provide a clear impetus for strengthened adverse event reporting oversight.

CONCLUSION

Your Committee on Scientific Issues and Committee on Health Information Technology reviewed the first resolve of Resolution 22, entitled "Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices," that was introduced at the 2019 MSS Interim Meeting (I-19). The resolution aims to address current gaps in the Food and Drug Administration's (FDA) eligibility criteria for approval of novel drugs and medical devices and calls on the FDA to adopt more stringent criteria regarding pre- and post-approval clinical trials, standards of evidence and reporting requirements.

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We found the resolution uses sufficiently convincing reasoning and resources to support their claims. There is also precedent for the asks of this resolution. The AMA has policy relating to the FDA's regulation of drugs, namely H-100.992. Moreover, we found there to be significant overlap between H-100.992 and Resolution 22. To that end, our recommendations address this by amending H-100.992 to include medical devices. We also recommend amending a number of subclauses from the original resolution.

Specifically, subclauses A, B, and F are addressed in AMA H-100.992 in terms of drugs, and we recommend the amendment of H-100.992 to include "and medical devices" following "drugs" in order to reduce redundancy in policy. Subclauses C and D of Resolution 22 both concern timely confirmatory trials, and therefore we recommend their merger into a succinct statement – seen below as the new subclause A. Subclause E asks the FDA to increase accountability for confirmatory trials. We found subclause E to be sufficiently addressed by current FDA policy, and for this reason, we recommend subclause E be struck. Subclause G addresses the need for a public, annual summary of medical devices approved under the expedited pathway with information on confirmatory trials. This subclause is well-founded, and we recommend its adoption with amendment to include reporting of adverse events – seen below as the new subclause B.

RECOMMENDATIONS

Your Committee on Scientific Issues and Committee on Health Information Technology recommends that the following recommendations are adopted, and the remainder of the report is filed:

1) That AMA policy H-100.992 be amended to include medical devices by addition to read as follows:

   FDA, H-100.992
   (a) an FDA decision to approve a new drug <u>or medical device</u>, to withdraw a drug <u>or medical device</u>'s approval, or to change the indications for use of a drug <u>or medical device</u> must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute;
   (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and
   (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug <u>or medical device</u> unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug <u>or medical device</u> is unsafe and/or ineffective for its labeled indications.

2) That the first resolved clause of MSS Resolution 22 be amended by addition and deletion as follows:

RESOLVED, That our AMA support the principles that:

~~(a) an FDA decision to approve a new medical device, to withdraw a medical device's approval, or to change the indications for use of a medical device must be based on sound scientific and medical evidence derived from controlled trials and/or post-market incident reports;~~

~~(b) the evidence for medical devices should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies, as appropriate;~~
~~(c) expedited programs for medical devices serve the public interest as long as sponsors for medical devices that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile;~~
~~(d) confirmatory trials for medical devices approved under accelerated approval should be planned at the time of expedited approval;~~
~~(e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for conducting confirmatory trials;~~
~~(f) any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a medical device unless the weight of the evidence from clinical trials and/or post-market incident reports prove that the medical device is unsafe and/or ineffective for its labeled indications; and~~

(a) confirmatory trials should be conducted in a timely fashion following accelerated approval of medical devices that are approved based on surrogate endpoints or limited evidence;

(b) ~~(g)~~ the FDA should make the annual summary of medical devices approved under expedited programs more readily available to the public and consider adding information on confirmatory clinical trials <u>and all reported adverse events</u> for such medical devices.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES

MSS CSI Report A
(November 2020)

Introduced by: MSS Committee on Scientific Issues

Subject: Supporting Daylight Saving Time As The New, Permanent Standard Time

Referred to: MSS Reference Committee
(Sarah Mae Smith , Chair)

INTRODUCTION

Daylight Saving Time (DST) in the United States, originally implemented periodically in the 1900s to sustain first and second world war industries and then to ease the 1973 oil embargo energy crisis, continues to be observed annually every second Sunday in March until the first Sunday in November.[1,22,34] Although “springing forward” and “falling back” is now accepted as a cultural norm, the utility of biannual time changing has been called into question in the modern era. Critics of the current standard argue that new data undermines the assumption of energy savings benefit and raises serious concerns about the potential for negative health consequences.[] In recent years, debate surrounding the implementation of a year-round standard time has reached multiple state legislatures as well as the 116th US Congress last year.[1,16-22,34,35,38,39]

The need for AMA policy on DST is evident as proposed legislation is being actively considered on the state and national level to abolish biannual time changing in favor of either year-round standard time or else year-round daylight time. The health concerns of biannual time changing align with issues addressed in current AMA policy identifying sleepiness as a major public health issue. “Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958” and “Insufficient Sleep in Adolescents H-60.930” both explore the consequences of fatigue on increased motor vehicle related injuries and decreased adolescent academic performance, as does “60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation;” however, no policy specifically addresses the contribution of DST to increased sleepiness amongst the American public.

In this active study, your Committee on Scientific Issues express three main reasons as to why the AMA should support the implementation of a year-round daylight time as the permanent standard time:

1.) Biannual time shifting contributes to significantly increased risk of adverse mental and physical health events;
2.) Daylight time is associated with broad, net positive public health, economic, and environmental effects; and
3.) There is significant national interest in establishing a permanent standard time.

BACKGROUND

Origin of DST

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Daylight savings time (DST), also referred to as summer time, is the practice of advancing clocks by one hour during the summer months and returning to the original standard time in winter months. Initially, DST was popularized by European countries such as Germany during World War I to reduce energy consumption. However, DST was unpopular in the United States and was not adopted until the end of the war and was abolished shortly after the war. After that, DST was implemented by local and state governments at their discretion. At the start of World War II, President Franklin D. Roosevelt instituted a year-round DST known as “War Time”. The idea behind this was, like during World War I, DST would conserve energy use and optimize resources for the war. After World War II, War Time was replaced with local implementation of DST.

Standardized method for DST in America

A standardized method for DST was implemented with the passage of the Uniform Time Act of 1966. The act mandated a standard time based on established time zones. This standard time would be advanced at 2:00 am on the last Sunday in April and reverted back to standard time the last Sunday in October at 2:00 am. Additionally, the bill gave states the option to exempt themselves from DST. Initially, Arizona and Michigan exempted themselves from DST, though in 1972 Michigan began to observe DST. Currently, Arizona, Hawaii, American Samoa, Puerto Rico and the Virgin Islands do not observe DST.

Alteration to DST in America

Since its passage, the Uniform Time Act has been amended or altered multiple times. In 1972, the act was amended to allow states split between time zones and to exempt the entire state or the part of the state in a different time zone. Additionally, the Department of Transportation was given power to enforce the law. During the energy crises in the mid 1970s, a trial period of year-round DST was introduced from 1974-1975. This change was controversial because despite the energy savings, there was concern about children leaving for school in the dark and morning accidents in the construction industry. Finally, DST was extended twice. The first time was in 1986 when DST start date was amended to the first Sunday of April. This was based on a Department of Transportation report that suggested there might be benefits in energy conservation, traffic safety and reduced violent crime. The second extension occurred with the passage of the Energy Policy Act of 2005, which extended DST to the second Sunday of March until the first Sunday in November. Reports after the passage of the act found a 0.03% in electricity savings in 2007 and increased shopping and commerce spending in the evenings.

Growing Call to End DST

In the last five years, there has been growing support to either end or legalize DST, with over 30 states (Figure 1) having proposals for consideration. The main argument for introducing year-round DST has been based on the idea that shifting the clock twice a year does not align with modern society and is associated with many short-term medical and public health concerns including decreased [quality] of sleep, increased rates of suicide, increased motor vehicle accidents, earlier stroke onset, increased percutaneous interventions for myocardial infarctions and decreased self-reported well-being. Currently, the only proposal at the federal level to make DST permanent is the Sunshine Protection Act of 2019, although many states have passed their own proposals.

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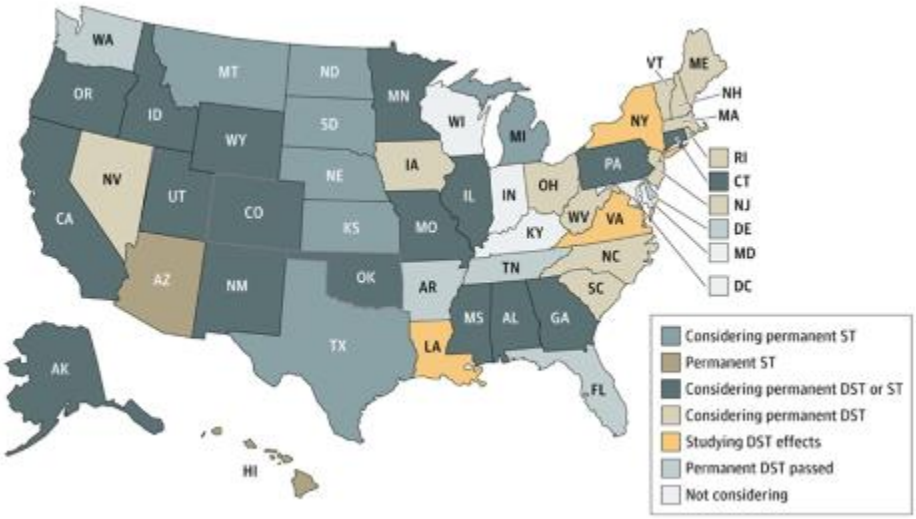

Figure 1. State legislative action on DST. Reprinted from Malow *et al.*, 2019.[30]

DISCUSSION

Before we discuss the benefits and drawbacks of the options before us, it is important to look at why a change in Daylight Savings Time (DST) practices is warranted. As has been discussed above, there have been a number of documented health deficits associated with the biannual change in wake time, most notably in the incidence of the onset of strokes. There have also been proposed associations between DST and cardiovascular health, fertility, and circadian rhythms, though these preliminary studies are not yet to the level of demonstrating true correlation. The time change also has an impact on mental health, most notably in the form of the effects of diminished sleep health. Outside of the scope of direct health impacts, there are indirect effects that must be considered as well: increases in workplace injuries, fatal motor vehicle collisions, and pedestrian fatalities. These health concerns were what first drew our attention to this issue and brought us to consider alternatives.

There is a precedence in the abolition of semiannual changing of time zones. Internationally, DST is typically observed throughout the Americas and Europe, with the implementation being less common in Asia and Africa. Within the United States, Arizona, Hawaii, and the island territories do not observe DST. Given the precedence set by these nations and states, as well as the recent legislative efforts in the US Senate, California, Michigan, Wisconsin, Texas, Pennsylvania, and Virginia, we feel that it is appropriate for the AMA to weigh in on this matter, with the health impact on our patients being a prominent talking point as this discussion continues to evolve.

Were we to change the current model to one without biannual time changes, a decision would need to be made between having continuous standard time and continuous daylight time. First we will evaluate the benefits and drawbacks of continuous standard time, followed by continuous standard time.

Much of the current support in our discussion behind the maintenance of standard time as the continuous nationwide default is in consideration of the alignment of the country with the states that do not currently follow DST changes, most notably Arizona and Hawaii. For the sake of continuity throughout the nation without undue burden beyond the elimination of the annual change, the selection of the current standard time would result in states in the same time zone all

being in alignment. While this is not an argument that has explicit or implicit benefits shown through scientific studies, we would be remiss if we didn't consider it purely for the simplicity factor. Changes that are widely perceived to be 'common sense' or 'simple' can often be accepted more easily by the general public, and thus more politically viable solutions. Here we found little evidence that the standard time was explicitly detrimental when compared to daylight time, so rather than look for flaws in the implementation of standard time, let's instead look to the studied benefits of daylight time.

The bulk of the scientific studies that we found regarding the time change phenomenon focused their efforts on outlining the benefits of daylight time over standard time, amongst studies that actually characterized the two. As was discussed above, these benefits include increased sleep hygiene, increased road safety, and diminished adverse health events. The modest increases in health outcomes related to the change should not be ignored simply because they are modest, but rather should be seen as a driving force towards continuous daylight time. Another important consideration is that the magnitude of these benefits is increased the further from the equator one goes. Many of the studies performed that found little to no significant benefit from continuous time and from daylight time were executed in areas that were closer to the equator, and have diminished effects from the DST change to begin with.

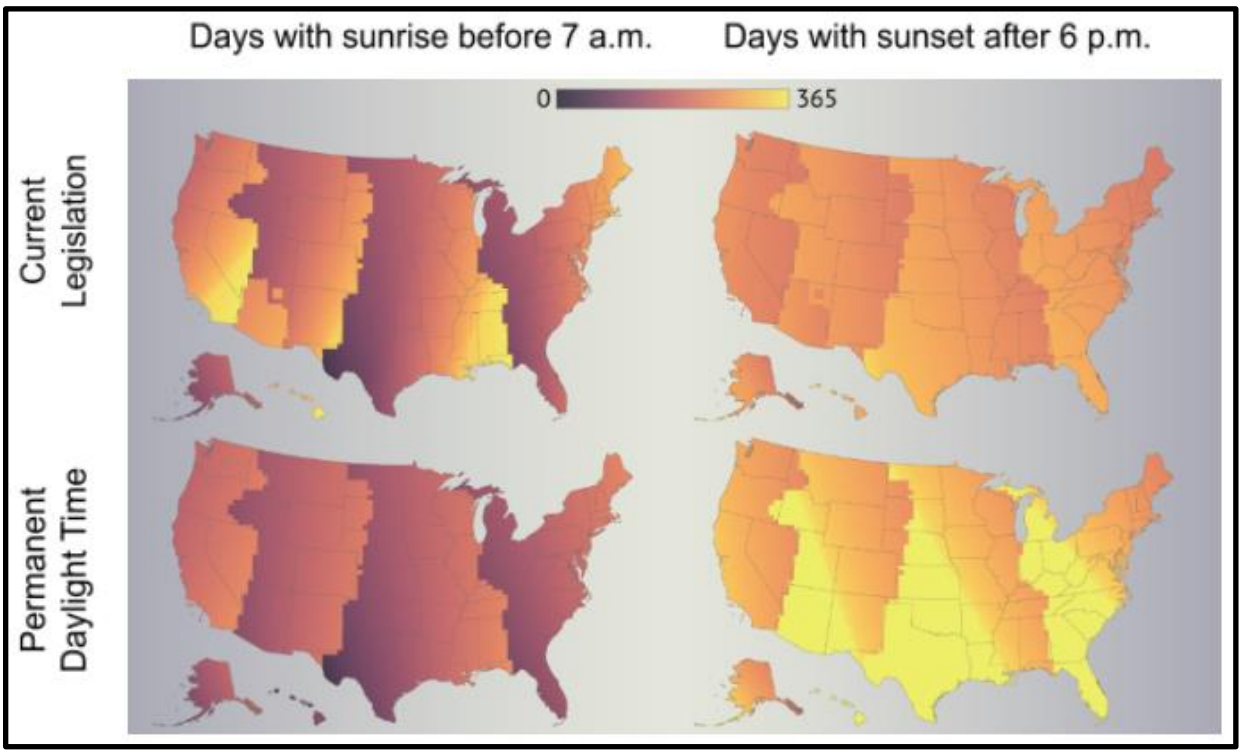

Figure 2. Days experiencing sunrise before 7 a.m. (left) and sunset after 6 p.m. (right) each year with biannual time changing, as implemented currently in state and federal legislation (top) and with permanent daylight time, as proposed herein (bottom). Reprinted from Woodruff, 2015.[44]

CONCLUSION

In conclusion of its active study on DST, your Committee on Scientific Issues has found research to support the abolishment of biannual time changing in support of year-round DST as the permanent standard time for the following reasons:

1. There are immediate adverse health effects following biannual time changing including net increased incidence of motor vehicle collisions, unipolar depression, in vitro fertilization pregnancy loss, suicidality, cardiovascular events, and workplace injury;
2. There are long-term health benefits of increased evening daylight including increased physical exercise in youth, reduced crime rates, and reduced pedestrian fatalities;
3. The purported environmental health, energy savings, and economic benefits of biannual time changing are negligible;
4. Multiple countries, states, and territories that previously implemented DST have already removed biannual time changing or are in the process of doing so; and
5. This policy aligns with existing AMA policy on Fatigue, Sleep Disorders, and Motor Vehicle Crashes (H-15.958) and Insufficient Sleep in Adolescents (H-60.930) and AMA-MSS policy on Altering School Days to Alleviate Adolescent Sleep Deprivation (60.022MSS).

RECOMMENDATIONS

Your Committee on Scientific Issues recommends that the following recommendations are adopted and the remainder of the report is filed:

RESOLVED, That our AMA support the elimination of biannual time changing; and be it further

RESOLVED, That our AMA support daylight saving time as the permanent standard time.

ACKNOWLEDGEMENTS

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RELEVANT AMA AND AMA-MSS POLICY

AMA policy on Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups; (2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions; (3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep; (4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment; (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology; (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice; (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state; (8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries; (9) reiterates its support for physicians' use of E-codes in completing emergency department and

hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
CSA Rep. 1, A-96; Appended: Res. 418, I-99

AMA policy on Insufficient Sleep in Adolescents H-60.930
1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.

2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.
Res. 503, A-10; Appended: CSAPH Rep. 06, A-16

Altering School Days to Alleviate Adolescent Sleep Deprivation 60.022MSS
That our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that the AMA support legislation congruent with those guidelines.
MSS Res 31, A-14; AMA Res 404, A-15 Referred; Reaffirmed: MSS GC Rep A, I-19

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REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(November 2020)

Introduced by: Stephanie Strohbeen, Chair

Subject: Policy Sunset Report for AMA-MSS Policies

Referred to: MSS Reference Committee
(Sarah Mae Smith, Chair)

INTRODUCTION

At the 1995 National Medical Student Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-95 and MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including:

- To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
- To assist in the identification of areas where additional policy is needed;
- To help identify and remove outmoded, duplicative, or inconsistent policies;
- To promote efficiency in Assembly deliberations; and
- To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044:

(1) Review of policies will be the ultimate responsibility of the GC; (2) policy recommendations will be reported to the MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.

MSS POLICY REVIEW

The MSS GC conducted a review of policies adopted or reaffirmed by the MSS Assembly in 2015. Appendix 1 of this report contains a listing of the 261 total policies adopted or reaffirmed in 2015, the recommendation for retention or rescission, and a brief supporting rationale for that recommendation. Many of these policies call for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy. The remaining policies contain general statements of policy that are still relevant, at least in part, and can be referenced by organizations or individuals seeking support for a particular issue. Of the 261 presented for consideration in this

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report, 255 of them will be either fully or partially retained as a part of the MSS policy compendium.

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.
2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

APPENDIX 1 – Policy Sunset Report Recommendations for AMA-MSS Policies

Policy #	Title	Policy	Recommendation
5.002MSS	Condemnation of Violence Against Abortion Clinics	AMA-MSS will ask the AMA to condemn the violence directed against abortion clinics and family planning centers as a violation of the right to access health care.	Retain - still relevant
10.002MSS	Fencing of Residential Pools	AMA-MSS strongly supports fencing of residential pools as a means to prevent immersion injury.	Retain - still relevant
10.003MSS	Mandatory Labeling for Waterbeds and Beanbag Furniture	AMA-MSS will ask the AMA to encourage waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and distribute warning materials on each waterbed and other furnishings concerning the risks of leaving an infant or ~~handicapped~~ child who lacks the ability to roll over unattended on a waterbed or beanbag furniture.	Retain - still relevant; amended to delete "handicapped"
10.006MSS	In-Line Skating Injuries	AMA-MSS will ask the AMA to: (1) strongly recommend that all in-line skaters wear protective helmets, wrist guards, and elbow and knee pads, and support efforts to educate adults and children about in-line skating safety; and (2) encourage the availability of all safety equipment at the point of in-line skate purchase or rental.	Retain - still relevant
10.010MSS	Return to Play After Suspected Concussion	AMA-MSS will ask the AMA to support the prohibition of athletes under age 18, who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, from returning to	Retain - still relevant

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		play or practice without a licensed health care provider's written approval.	
10.011MSS	Skiing and Snowboarding Helmets and Safety	AMA-MSS will ask the AMA to (1) actively support skiing and snowboarding helmet use and encourage physicians to educate their patients about the importance of skiing and snowboarding helmet use; (2) encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced skiing and snowboarding helmets; (3) encourage the availability of helmets at the point of skiing and snowboarding purchase; and (4) develop model state/local legislation requiring the use of skiing and snowboarding safety helmets in the pediatric population, and calling for all who rent skis and snowboards to the pediatric population to offer the rental of skiing and snowboarding safety helmets.	Retain - still relevant
15.001MSS	State Motorcycle Helmet Laws	AMA-MSS will ask the AMA to: (1) endorse the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urge constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws.	Retain - still relevant
15.003MSS	Mandatory Seat Belt Utilization Laws	AMA-MSS will ask the AMA to support mandatory seat belt utilization laws, which do not simultaneously relieve automobile manufacturers of	Retain - still relevant

		their responsibility to install passive restraints.	
15.010MSS	Seat Belt Compliance in Emergency Vehicle Patient Compartments	AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care.	Retain - still relevant
20.009MSS	Condom Availability	AMA-MSS will ask the AMA to pursue legislation that encourages local, state, and federal correctional institutions to make condoms available to the inmates.	Retain - still relevant
20.010MSS	Comprehensive HIV Programs in Correctional Facilities	AMA-MSS will ask the AMA to encourage correctional systems at the federal and state levels to provide comprehensive medical management to all prisoners, including treatment, counseling, education, and preventive measures related to HIV infection.	Retain - still relevant
20.011MSS	Non-Consensual HIV Testing	AMA-MSS will ask the AMA to support allowing HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with the HIV virus in federally operated health care facilities.	Retain - still relevant
20.015MSS	National HIV Testing Day	AMA-MSS will ask the AMA to recognize National HIV Testing Day and encourage AMA	Retain - still relevant

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		members to promote participation in voluntary HIV testing and counseling through community and media outreach, health fairs, and free testing sites across the country.	
20.016MSS	Anonymous HIV Testing on Undergraduate Campuses	AMA-MSS will ask the AMA to encourage undergraduate campuses to conduct anonymous, free HIV testing with qualified staff and counselors.	Retain - still relevant
20.017MSS	HIV Positive Immigration and Permanent Residency in the U.S.	AMA-MSS will ask the AMA to amend H-20.901 by insertion and deletion as follows: H-20.901 HIV, Immigration, and Travel Restrictions Our AMA: (1) Supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649); (2) Recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; ~~(3) Supports keeping HIV infection on the list of communicable diseases of "Public Health Significance" for purposes of immigration law and supports excluding immigrants infected with HIV from settling permanently in the United States;~~ (3~~4~~) Recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4~~5~~) Recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.	**Sunset - these changes have been passed**

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25.002MSS	Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood	AMA-MSS will ask our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible.	Retain - still relevant
30.001MSS	Medical Student and House-Staff Alcoholism	AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students.	Retain - still relevant
30.003MSS	Age-Requirement for Purchase of Non-Alcoholic Beer	AMA-MSS will ask the AMA to: (1) support accurate and appropriate labeling disclosing the alcohol content of all beverages including so-called "non-alcoholic" beer and of other substances as well, including over-the-counter and prescription medications with removal of "non-alcoholic" from the label of any substance containing any alcohol; (2) support efforts to educate the public and consumers relating to the alcohol content of so-called "non-alcoholic" beverages and other substances, including medications, especially as related to consumption by	Retain - still relevant

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		minors; and (3) express strong disapproval of any consumption of beer by persons under 21 years of age which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol.	
30.005MSS	Boating Under the Influence	AMA-MSS will ask the AMA to (1) support legislation for adequate education on the dangers of alcohol and drug consumption for the safe operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.	Retain - still relevant
55.002MSS	Mass Screening for Neuroblastoma	AMA-MSS will ask the AMA to encourage the implementation of mass screening programs for neuroblastoma in each state and work to increase public awareness of the benefits of a mass screening program for neuroblastoma.	Retain - still relevant
55.003MSS	Screening and Education Programs for Breast and Cervical Cancer Risk Reduction	AMA-MSS will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2) support government funded programs available for low income women; and (3) support the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer.	Retain - still relevant
60.002MSS	Provision of Health Care and Parenting Classes to Adolescent Parents	AMA-MSS will ask the AMA to (1) encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings that provide health care for infant	Retain - still relevant

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		and mother and child development classes in addition to current high school courses and (2) support programs directed toward increasing high school graduation rates, improving parenting skills, and decreasing future social service dependence of teenage parents.	
60.006MSS	First Aid Training for Child Daycare Workers	AMA-MSS will ask the AMA to recommend that all licensed child daycare facilities have a minimum of one employee currently certified in first aid including adult/pediatric and infant CPR and foreign body airway management, on site and available during all business hours.	Retain - still relevant
60.010MSS	Encouraging Vision Screening for Schoolchildren	AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate.	Retain - still relevant
60.011MSS	Sun Protection Programs in Elementary Schools	AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies.	Retain - still relevant
60.014MSS	Establishment of a National Immunization Registry of "Vaccines for Children" Enrolled Patients	AMA-MSS will ask the AMA to (1) work with ~~the Centers for Disease Control, the Department of Health and Human Services, the United States Public Health~~	Retain - still relevant; strike out specific organizational entities

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		~~Service Health, and other~~ interested organizations to develop a National Immunization Registry (NIR) that considers the use of information technology to manage and access information contained within it and (2) ensure that any National Immunization Registry (NIR) that is created protects the patient-physician relationship.	
60.018MSS	Body Image and Advertising to Youth	AMA-MSS will ask the AMA to encourage advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner than could promote unrealistic expectations of appropriate body image.	Retain - still relevant
60.019MSS	Reducing the Incidence of Back Pain in School Children by Encouraging the Proper Use of Backpacks	AMA-MSS supports guidelines to encourage proper use of backpacks by school children by recommending lighter loads and the use of both shoulders.	Retain - still relevant
65.010MSS	Promoting Awareness and Education of LGBTQ+ ~~Lesbian, Gay, Bisexual, and Transgender~~ Health Issues on Medical School Campuses	AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in LGBTQ+ ~~Lesbian, Gay,~~	Retain - still relevant; amended to expand to full LGBTQ+ communities

		~~Bisexual, and Transgender~~ communities; (3) encourages the LCME to require all medical schools to incorporate LGBTQ+ ~~GLBT~~ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation.	
65.011MSS	Physician Objection to Treatment and Individual Patient Discrimination	AMA-MSS will ask the AMA to: (1) reaffirm that physicians can conscientiously object to the treatment of a patient only in non-emergent situations; and (2) support policy that when a physician conscientiously objects to serve a patient, the physician must provide alternative(s) which include a prompt and appropriate referral.	Retain - still relevant
65.014MSS	Marriage Equality and Repeal of the Defense of Marriage Act	~~(1)~~ AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting LGBTQ+ ~~those gay and lesbian~~ individuals and couples, their families, and their children~~; (2) AMA-MSS supports the repeal of the "Defense of Marriage Act," as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the gay, lesbian, bisexual, and transgender (GLBT) community.~~	Retain - still relevant; strike R2 because this portion of the Defense of Marriage Act was ruled unconstitutional in 2013; amended to expand to LGBTQ+
65.020MSS	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	AMA-MSS will ask (1) that our AMA urge long-term care facilities and other appropriate organization to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or	Retain - still relevant

		abusive situations, and (2) with in-service training to develop a framework to address intimacy in their patient population.	
75.001MSS	Mandatory Parental Notification for Minors Seeking Contraceptive Devices	AMA-MSS supports the concept that primary prevention of unplanned pregnancy, particularly among the young, is a public health priority; expressed concern that requiring notification and verification of contraceptive care to minors may increase the number of teenagers at risk of unplanned pregnancies by establishing a real or perceived barrier to a primary preventive health service.	Retain - still relevant
75.013MSS	Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement	AMA-MSS will ask (1) that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost-effective way of reducing future unintended pregnancies; (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures.	Retain - still relevant

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90.002MSS	National Campaign for Educate School Teachers on Interaction with Impaired Children	AMA-MSS will ask the AMA to encourage physicians, medical students and other health care professionals to participate in the education of teachers on common pediatric impairments.	Retain - still relevant
90.007MSS	Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization	AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers.	Retain - still relevant
95.001MSS	Inhalant Abuse	AMA-MSS will ask the AMA to support education and awareness among medical professional and the public regarding inhalant abuse.	Retain - still relevant
95.002MSS	Methamphetamine Abuse	AMA-MSS will work to educate members on the health impacts of methamphetamine manufacture and abuse and will support national and state legislation that regulates pseudoephedrine availability and accessibility to prevent the use of pseudoephedrine for non-medical purposes.	Retain - still relevant
100.002MSS	Opposition to Abuses of the Orphan Drug Act	AMA-MSS will ask the AMA to oppose abuses of the intent of the Orphan Drug Act.	Retain - still relevant
100.004MSS	AMA Support for the Use of Patient Controlled Analgesia (PCA)	AMA-MSS will ask the AMA to support the use of Patient Controlled Analgesia (PCA), when not contraindicated, as one of several effective analgesic methods.	Retain - still relevant
100.007MSS	Naloxone Administration and Heroin Overdose	AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-	Retain - still relevant

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		prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine.	
100.012MSS	Support for the Use of Pain Contracts	AMA-MSS supports a physician's discretionary utilization of pain contracts/agreements while prescribing opioids.	Retain - still relevant
100.013MSS	OTC Availability of Naloxone	AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone.	Retain - still relevant
100.014MSS	Drug Pricing Reform	AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies.	Retain - still relevant
100.015MSS	Addressing the U.S. Drug Shortage Crisis	AMA-MSS will ask the AMA to support the repeal of the "Anti-Kickback Safe Harbor" for Group Purchasing Organizations.	Retain - still relevant
105.001MSS	Drug Advertising to the Public	AMA-MSS will ask the AMA to oppose the promotion of drugs	Retain - still relevant

		in the absence of reasonable evidence for claims made.	
105.002MSS	FDA Regulation of OTC Medication Advertising	AMA-MSS supports increased oversight of over-the-counter medication advertising, applying similar standards that are applied to prescription medication advertising.	Retain - still relevant
115.001MSS	Fingerstick and Single-Use Point-of-Care Blood Testing Devices Should not be Used for More than One Person	AMA-MSS will ask the AMA to encourage improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients.	Retain - still relevant
120.003MSS	Advocacy for Research into the Effects of Psychotropic Drugs in Children	AMA-MSS will ask the AMA to: (1) work in conjunction with ~~the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and other~~ relevant organizations to encourage increased funding for research into the safety and efficacy of psychotropic medications in children, especially those under 4 years of age, adolescents, and young adults; (2) establish diagnostic criteria for use of these medications in children, adolescents, and young adults; (3) promote incentives to create the infrastructure necessary to carry out studies related to the effects of psychoactive drugs in children, adolescents, and young adults, expressly to train qualified clinical investigators in pediatrics, child psychiatry, and pharmacology; and (4) promote efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults.	Retain - still relevant; edit to remove references to specific professional health organizations

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120.007MSS	Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy	AMA-MSS: (1) supports ~~the American Pharmaceutical Association in ensuring that~~ pharmacies and ~~pharmacists set up~~ systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; and (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference.	Retain - still relevant; edit to remove reference to specific organization
120.008MSS	Decreasing Epinephrine Auto-Injector Accidents and Misuse	AMA-MSS will ask the AMA to (1) encourage physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and (2) encourage improved product design and labeling of epinephrine auto-injectors.	Retain - still relevant
120.012MSS	Prior Authorization Reform	AMA-MSS supports prescription prior authorizations reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, and exceptions for urgent care access.	Retain - still relevant
135.005MSS	Promotion of Conservation Practices within the AMA	AMA-MSS will ask the AMA to direct its offices to implement conservation-minded practices whenever feasible.	Retain - still relevant
135.006MSS	Recycling	AMA-MSS encourages and supports all efforts to further hospital recycling.	Retain - still relevant
135.009MSS	Public Notification of Pesticide Applications	AMA-MSS will ask the AMA to support improved public notification of pesticide	Retain - still relevant

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		applications and recommend that clearly visible signs be posted a reasonable time before and after commercial pesticide applications.	
135.013MSS	Statement of Sustainability Principles	AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods.	Retain - still relevant
140.002MSS	Bioethical Determinations	It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their	Retain - still relevant

		therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions for health care in the non-competent patient.	
140.003MSS	Hospital Ethics Committees	AMA-MSS will ask the AMA to take an active role consistent with its existing policy and encourage the continued development of hospital=based multi-disciplinary review committees designed to address ethical concerns, including the health care of persons with disabling conditions.	Retain - still relevant
140.020MSS	Increasing Physician Presence in Online Social Networks	AMA-MSS recommends that physicians, medical students, and other members of the medical community educate themselves both about the advantages and increased communication opportunities provided by social networks, but also about the liability and patient confidentiality issues presented.	Retain - still relevant
140.023MSS	Responsible Biomedical and Bioethics Journalism	AMA-MSS will ask the AMA to (1) encourage responsible biomedical and bioethics journalism; and (2) support the efforts of ~~the Association of Health Care Journalists and~~ other organizations to promote responsible biomedical and bioethics journalism.	Retain - still relevant; edit to remove reference to specific organizations

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140.029MSS	Ethical Parameters for Recommending Mobile Medical Applications	AMA-MSS will ask the AMA to examine the issues related to physicians recommending medical software and apps to patients, especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically.	Retain - still relevant
140.031MSS	Accommodations for Treatment of Medical Students and Residents	AMA-MSS asks the AMA to study the power-dichotomy between physician and trainee in their position on peers as patients.	Retain - still relevant
150.001MSS	Medical Education in Nutrition	AMA-MSS will ask the AMA to encourage the institution of a core course in nutrition in the basic science curriculum of US medical schools.	Retain - still relevant
150.002MSS	Revision of Dietary Guidelines for Americans	AMAMSS will ask the AMA to: (1) support alterations of "Dietary Guidelines for Americans" only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of "Dietary Guidelines for Americans" should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act.	Retain - still relevant
150.005MSS	Mandatory Federal Inspection of Fresh Fish and Shellfish	AMA-MSS will ask the AMA to support a federal action, regulatory or legislative as appropriate, that would require mandatory safety inspection of handling of fresh fish and shellfish sold in the United States.	Retain - still relevant
150.022MSS	Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners	AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic	Retain - still relevant

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		beverages containing caloric sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition.	
150.023MSS	Price Parity in Fast Food Children's Meals	AMA-MSS will ask the AMA to ~~(1)~~ encourage fast food restaurants to establish price parity between traditional side items and alternative, more healthful options in children's meals.~~; and (2) work directly with the White House's Let's Move Program to support the fast food industry in establishing price parity between traditional side items and alternative, more healthful options in children's meals.~~	Retain - still relevant; edit to remove reference to specific & outdated program
155.001MSS	Listing of Hospital Charges	AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, house-staff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms.	Retain - still relevant
155.002MSS	Cost Containment	AMA-MSS will ask the AMA to encourage medical schools and hospitals to orient medical students beginning in their clinical training and the house-staff to the costs of laboratory tests and procedures.	Retain - still relevant
160.014MSS	Recognizing the Important Role of	AMA-MSS (1) recognizes the importance of advanced practice	Retain - still relevant; updated language

	Advanced Practice Providers ~~Physician Extenders~~ in the Multidisciplinary Patient Care Team	providers ~~nurses, nurse practitioners, and physician assistants~~ to the multidisciplinary patient-care team; (2) recognizes that the physician is the leader of the multidisciplinary patient care team, and that there are distinct differences in training, both in time and content, between physicians and advanced practice providers ~~physician extenders~~; and (3) supports the patient centered medical home model and the role of physicians therein as the primary medical decision makers.	
160.015MSS	Advanced Practice Providers ~~Physician Extenders~~	(1) AMA-MSS opposes any legislation that seeks to expand the scope of practice of advanced practice providers ~~physician extenders~~ beyond the level of expertise their training provides, and without the appropriate oversight of a physician; (2) AMA-MSS will ask the AMA to (a) support innovative reimbursement strategies for primary care physicians that reward the use of advanced practice providers ~~physician extenders~~ to meet demand for health care services by increasing capacity for delivering care; (b) engage societies of physician extenders to develop consensus recommendations for scope of bodies; and (c) oppose, in academic environments, payment models for advanced practice providers ~~physician extenders~~ that interfere with graduate medical training, such as productivity bonuses and surgical assisting fees.	Retain - still relevant; updated language from physician extenders to advanced practice providers

160.017MSS	Study of Interpreter Mandate	AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English.	Retain - still relevant
160.018MSS	Investigating Cost-Saving, Equitable Care in Direct Practice Medicine	AMA-MSS will ask the AMA to (1) investigate~~, with the American Academy of Private Physicians,~~ the potential for direct practice medicine to serve as a cost saving tool for certain patients requiring 24-hour access to care; and (2) investigate~~, with American Academy of Private Physicians,~~ the scope of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine to include all classes.	Retain - still relevant; edit to remove reference to specific professional organizations
160.030MSS	Including Military History as Part of Standard History Taking	That our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources.	Retain - still relevant
160.031MSS	Concurrent Hospice and Life-Prolonging Care	AMA-MSS ask the AMA to amend policy H-85.955 by insertion and deletion as follows: H-85.955 Hospice Care Our AMA: (1) approves of the physician-directed hospice	**Sunset - amendment was made**

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

		requirement from 6 to 12 months as an interim measure; and (7) ~~seek amendment of~~ supports changes in ~~the~~ Medicare regulation ~~law~~ to ~~eliminate the requirement that life-prolonging care be terminated before hospice will be reimbursed~~ allow provision of concurrent curative and hospice care.	
165.012MSS	Covering the Uninsured as AMA's Top Priority	AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid and improving the physician practice environment.	Retain - still relevant
165.018MSS	Study of Current Trends in Clinical Documentation	AMA-MSS will ask (1) that our AMA study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation, and (2) that our AMA study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education.	Retain - still relevant
170.001MSS	Prevention and Health Education	AMA-MSS supports the following principles: (1) Health Education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventative services and health education to employees; (3) All health care professions should	Retain - still relevant

		be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis on preventative medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) anti-smoking, (c) enforcement of drunk driving laws, (d) mandatory use of seatbelts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and (8) Preventive health services should be made available to all population segments, especially those at high risk.	
170.002MSS	Radioactive Substance Education in Public Schools	AMA-MSS will ask the AMA to encourage the teaching of the fundamental aspects of exposure to low level ionizing radiation in the health education provided in secondary schools.	Retain - still relevant
170.003MSS	Incorporation of Adoption into Public School Health Education Curriculum	AMA-MSS will ask the AMA to support the incorporation of information on adoption into public school sex education or family planning curricula.	Retain - still relevant

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170.004MSS	Health Education	AMA-MSS will ask the AMA to urge all state medical societies to urge their respective state departments of education to implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and seek funding for these programs. These health education programs should contain provisions for educator raining and development of local community health advisory committees.	Retain - still relevant
170.005MSS	Teaching Sexual Restraint to Adolescents	AMA-MSS will ask the AMA to: (1) support efforts in the mass media, schools, and communities to make abstinent sexual behavior more socially acceptable and to help students develop the skills and self-confidence they need to restrict their sexual behavior; and this support will include efforts to increase funding and policies at the local, state, and federal levels, though not necessarily at the expense of existing policies; and (2) encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity.	Retain - still relevant
170.011MSS	Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula	AMA-MSS will ask the AMA To strongly urge existing school health education programs to emphasize the high incidence of human papillomavirus and to discuss the importance of routine pap smears in the prevention of cervical cancer.	Retain - still relevant

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170.012MSS	Nutrition Education for Parents of School-Aged Children	AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to education parents about healthy lifestyles in an effort to prevent and reduce the prevalence of overweight and obesity in children and adolescents	Retain - still relevant
170.017MSS	Stem Cell Tourism	AMA-MSS will ask (1) that our AMA study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment, and (2) that our AMA encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues.	Retain - still relevant
180.001MSS	Consumer Choice Principles	AMA-MSS supports the following AMA principles for any consumer choice health plan that might be adopted~~, as contained in AMA Board of Trustees Rep C (I-82): (1) Multiple Choice of Plans – Insurance Coverage options should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer health benefit plans and, if they choose to offer coverage, to offer employees a choice from among multiple options. (2)~~ (1)Minimum Benefits – Health insurance plans offered employees should contain required minimum benefits, including catastrophic coverage. ~~(3) Equal Contributions – Equal employer contributions should~~	Retain - still relevant; strike "as contained in AMA Board of Trustees….multiple options" because it conflicts with policy 165.020MSS

		~~be made for health benefit plans, regardless of the plan selected by the employee. (4)~~ (2) Non-Taxable Rebate to Employees- Employees should receive a non-taxable rebate where an employee chooses a plan option costing less than the amount of the employer contribution. ~~(5)~~(3) Maximum Contribution Limitation – A limit (adjustable for inflation) should be placed on the amount of health insurance premiums paid by an employer for tax deduction by the employer as a business expense. Amounts paid in excess of this limit would be taxable income to the employee. ~~(6)~~ (4)Employer Non-Compliance – Unqualified plans should not be eligible for tax deduction.	
180.002MSS	Prospective Payment/Reimbursement	AMA-MSS endorses the concept of prospective reimbursement as a means of reducing the cost of health care without endorsing any specific plan.	Retain - still relevant
180.003MSS	Equitable Reimbursement for Physicians' Cognitive Services	AMA-MSS supports the concept that third-party payors should provide equitable reimbursement for physicians' cognitive services.	Retain - still relevant
180.008MSS	Insurance for Domestic Partners	AMA-MSS will ask the AMA to encourage state medical societies to seek legislation in their states that would assure the eligibility of health care benefits for same sex and opposite sex partners and their children consistent with the eligibility of spouses of married employees/students and the children of these spouses.	Retain - still relevant
200.003MSS	AMA Opposition to Primary Care Quotas	AMA-MSS will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose	Retain - still relevant

		efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to increase the number of primary care physicians.	
200.006MSS	National Physician Workforce Planning	AMA-MSS will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent national workforce planning body should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation.	Retain - still relevant
200.007MSS	Role of ACGME in Work Force Planning	AMA-MSS opposes the proposed new role of the Accreditation Council for Graduate Medical Education to provide residency program quality assessments to governmental work force policy boards for their use in residency needs planning.	Retain - still relevant
200.008MSS	Regional Work Force Planning Boards	AMA-MSS supports the concept that any national workforce planning efforts be research-based and take into account regional needs and variations.	Retain - still relevant
200.010MSS	Primary Care Internships	AMA-MSS will ask the AMA to encourage state medical societies, in conjunction with primary care specialty societies, to promote and encourage primary care internship and/or preceptorship programs for medical students in their states as a positive means toward increasing the number of primary care physicians.	Retain - still relevant

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200.012MSS	Availability of Information on Physician Workforce Needs for Residency Applicants	AMA-MSS will ask the AMA to support measures to increase the availability of information on specialty choice to medical students by gathering and disseminating information on market demand and health manpower needs for the medical and surgical specialties.	Retain - still relevant
200.017MSS	Medical Student Representation in National Health Service Corps Planning	AMA-MSS will advocate to increase medical student representation in the decision-making process of the National Health Service Corps ~~during the implementation of the Patient Protection and Affordable Care Act~~.	Retain - still relevant; strike out Act as that has been implemented
215.004MSS	Banning the Sale of Sugar-Sweetened Beverages in Hospitals	AMA-MSS supports measures that restrict retail or vending machine sales of sugar-sweetened beverages in hospitals, clinics, or food service outlets that operate in space owned by licensed health care facilities.	Retain - still relevant
245.001MSS	Cardiopulmonary Resuscitation Training for Expectant and New Parents	AMA-MSS will ask the AMA to encourage CPR training of new and expectant parents at childbirth preparation classes, prenatal clinics, and sites of well-baby pediatric visits.	Retain - still relevant
245.002MSS	AMA Support for Breastfeeding	AMA-MSS will ask the AMA to encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents	Retain - still relevant

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		about formula and bottle-feeding options.	
245.003MSS	Sudden Infant Death Syndrome	AMA-MSS will ask the AMA to encourage the education of parents, physicians, and all other health care professionals involved in newborn care regarding methods to eliminate known SIDS risk factors~~, such as prone sleeping, soft bedding, and parental smoking~~.	Retain - still relevant; amended to strike out specific risk factors, which may be updated
245.010MSS	Safe Haven for Newborns	AMA-MSS supports efforts to lower barriers to adoption including the coordination of anonymous adoption and supports state efforts to decrease the number of abandoned infants by supporting legislation that would protect mothers from prosecution who anonymously deliver their infant safely to a licensed health care facility, thus enabling the facility to initiate the adoption process.	Retain - still relevant
245.015MSS	AMA Stance on Physician Scripts and Support for Ongoing Fetal Pain Research	AMA-MSS will ask the AMA to encourage further unbiased research on fetal pain and to oppose government-mandated physician scripts.	Retain - still relevant
245.017MSS	Early Hearing Detection and Intervention	AMA-MSS will ask the AMA to (1) support Early Hearing Detection and Intervention (EHDI) to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and (2) support federal legislation to provide appropriate resources, coordination, and education for EHDI follow-up with infants who fail initial hearing screening tests.	Retain - still relevant
250.001MSS	Medical Care in Countries in Turmoil	AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical	Retain - still relevant

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		equipment to civilians threatened by natural disaster or military conflict withing their country; (2) express concern about the disappearance of physicians, medical students, and health care professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries.	
250.022MSS	Foreign Emergency Medical Relief Policy and Procedures for Hospitals	AMA-MSS will ask the AMA to encourage ~~the American Hospital Association~~ relevant stakeholders to develop policies and procedures to facilitate the coordination of logistics in the event of an international disaster requiring urgent emergency medical relief.	Retain - still relevant; strike out names of specific organizations
250.025MSS	Voluntary Reporting of Complications from the Medical Tourism	AMA-MSS will ask that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad.	Retain - still relevant
255.001MSS	The Status of Foreign Medical School Graduates in the United States	AMA-MSS supports the following principles: (1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the	**Sunset - this policy goes against the spirit of policy 255.003MSS.**

		rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (3) Immigration legislation should allow adequate time to complete training. (4) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country. (5) Determination of an individual's qualifications should include assessment of the individual student or medical school graduate as well as the foreign medical school attended. (6) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession as well as residency training programs' preference for graduates of US medical schools.	
255.002MSS	Foreign Medical School Documentation	AMA-MSS supports the concept that students from non-accredited medical schools be required to adequately document their clinical clerkships as a prerequisite for licensure and ECFMG certification.	**Sunset - conflicts with 255.003MSS**
255.003MSS	Licensure of International Medical Graduates	AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the development of separate licensing criteria, including exams, for any group.	Retain - still relevant
270.001MSS	Support of Legislation Affecting Medical Students	AMA-MSS will ask the AMA to establish guidelines so that state societies would, when considering legislation affecting	Retain - still relevant

		medical students, solicit input from medical school student governments, consider student views, and inform the medical student governments of decisions on these issues.	
270.004MSS	Policy on the "Gag Rule"	AMA-MSS will ask the AMA ~~to actively work with Congress and other involved organizations~~ to oppose any legislation and/or regulation that would interfere with a physician's ability to provide information about all treatment options available to his or her patients, and/or that would interfere with the privacy of the physician-patient relationship.	Retain - still relevant; strike out any entities
270.006MSS	Tax on Health Care Providers	AMA-MSS will ask the AMA to strongly oppose the imposition of a selective revenue tax on health care providers by Congress and state legislatures in order to fund health care programs.	Retain - still relevant
270.022MSS	Promoting Transparency to Stimulate Improved Quality	AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making.	Retain - still relevant
270.029MSS	AMA Support for Justice Reinvestment Initiatives	AMA-MSS will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs.	Retain - still relevant
275.001MSS	Competence for Licensure	AMA-MSS will ask the AMA to: (1) urge state licensing authorities to continue to recognize the NBME certificate;	Retain - still relevant; strike outdated FLEX exam

		(2) recommend that medical school faculties continue to exercise responsibilities for evaluating students and house-staff; (3) oppose a licensing examination as a requirement for graduates of educational programs accredited by the LCME to enter the first year of graduate training; (4) oppose requirements for licensure requiring a long period of graduate education with the attendant risk of licensure by specialty~~; and (5) support a single FLEX examination sequence, during or shortly after the first year of graduate medical education.~~	
275.002MSS	Interns' Qualifications	AMA-MSS (1) endorses the concept that an MD <u>or DO</u> degree by an accredited U.S. medical school is a sufficient qualification for the intern to administer medical care as a member of the house-staff treatment team; and (2) opposes any attempts to impose additional requirements ~~(e.g., FLEX I)~~ in order to function as an intern.	Retain - still relevant; added DO; strike mentions of the FLEX exam
275.003MSS	Use of Licensing Examination Scores	AMA-MSS supports AAMC efforts to urge the National Board of Medical Examiners to issue only pass-fail results of the National Board examination.	Retain - still relevant
280.001MSS	Quality of Nursing Homes	AMA-MSS will ask the AMA to express publicly its concern for inadequate nursing home care, advocate high standards for such care, and support efforts to establish adequate funding of nursing and convalescent homes that would allow them to maintain qualified personnel.	Retain - still relevant

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295.001MSS	Support Groups	AMA-MSS will ask the AMA to encourage the development of alternative methods for dealing with the problems of student-physician mental health in medical schools and that these alternatives be available to students at the earliest possible point in their medical education.	Retain - still relevant
295.002MSS	Training in Sign Language	AMA-MSS endorses the concept of training physicians in total communication with the deaf and hard of hearing, and encourages utilization of existing programs in sign language and total communications with the deaf and hard of hearing.	Retain - still relevant; added "and hard of hearing"
295.003MSS	Guidelines for Do-Not-Resuscitate Orders	AMA-MSS will ask the AMA to enlist the support of the Association of American Medical Colleges in recommending that medical schools, as part of their educational curriculum for medical students, include the ethical, legal, and emotional aspects surrounding do-not-resuscitate orders.	Retain - still relevant
295.004MSS	Medical Student Education Concerning Physician Impairment	AMA-MSS will ask the AMA to urge state medical societies to approach medical schools and medical student groups to offer the services of volunteer physicians knowledgeable about physician impairment as speakers and discussion leaders.	Retain - still relevant
295.006MSS	Geriatric Medicine	AMA-MSS will ask the AMA to reaffirm its position for the incorporation of geriatric medicine into the curriculum of major medical school departments and its position of emphasizing further education and research on the problems of aging and health care of the aged at the medical school,	Retain - still relevant

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		graduate and continuing medical education levels.	
295.027MSS	Adequate Insurance for Medical Students and Residents	AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.	Retain - still relevant
295.029MSS	Medical Student Legislative Awareness	AMA-MSS will recommend that: (1) medical students actively	Retain - still relevant

		encourage state medical societies to sponsor legislative awareness workshops for students and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues.	
295.034MSS	Commendation of the AMA for Support of Medical Education Funding	AMA-MSS commends the AMA for its continued support of medical education funding through AMA investigations endorsements, legislative activity, and monetary contributions.	Retain - still relevant
295.035MSS	Medical School Waiting Lists	AMA-MSS recommends that prospective medical students keep medical schools informed about their decision-making process with respect to acceptances, including turning back acceptances to medical schools as soon as a decision not to attend has been made.	Retain - still relevant
295.044MSS	Effective Education for the Future of Medicine	The AMA-MSS Governing Council will continue to identify opportunities to present timely and relevant health policy information to medical students.	Retain - still relevant
295.054MSS	Commonwealth Puerto Rican as a Minority Group	AMA-MSS will ask the AMA to recognize all Puerto Ricans, regardless of place of residence (Commonwealth or mainland), as an underrepresented minority when applying to mainland medical schools and convey this policy to the Association of American Medical Colleges and other bodies as appropriate.	Retain - still relevant
295.056MSS	Phlebotomy Training in Medical Schools	AMA-MSS will ask the AMA to encourage medical schools	Retain - still relevant

		curriculum committees to update their phlebotomy training programs to promote mastery of blood drawing skills through ample practice and to educate students regarding post-exposure protocols in the event of a needle stick injury, before entering clinical rotations.	
295.057MSS	Child Care Resource Information for Medical Students	AMA-MSS will advocate the provision of child care resources at medical schools, including the availability of on-site child care (day and night) as well as information regarding subsidies for child care and information on child care alternatives for those parents who do not use the on-site services or whose institution is unable to accommodate such services.	Retain - still relevant
295.058MSS	Suicide Prevention Program for Medical Students	AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective.	Retain - still relevant
295.061MSS	Support for Women's Health Training	AMA-MSS supports efforts to promote the multidisciplinary incorporation of women's health education and training across all medical specialties and in medical school, residency training, and continuing medical education.	Retain - still relevant
295.063MSS	Student Workhouse Reform	AMA-MSS will ask the AMA to work diligently toward medical education reform that will train its future physicians in a more effective and humanistic environment.	Retain - still relevant
295.066MSS	Medical Student Impairment Policies	AMA-MSS will ask the AMA to: (1) strongly encourage medical schools that have not yet established policy on medical student impairment and implemented programs to	Retain - still relevant

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		prevent and treat student impairment to do so immediately; and (2) stress to medical schools the importance of increased information and visibility of medical student impairment policy and programs for the student body and that resources should be made readily available to the students throughout medical school and reiterated at the beginning of each year.	
295.067MSS	Medical Education about Rape Crises	AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of rape victims, and available rape support groups into their clinical preparation curriculum.	Retain - still relevant
295.068MSS	Medical School and Occupational Exposure	AMA-MSS encourages institutions to continually educate their students on occupational exposure protocols and encourage medical students to become well-informed and aware of the relevant procedures.	Retain - still relevant
295.104MSS	Privacy and Confidentiality of Medical Students in Physical Diagnosis Classes	AMA-MSS supports the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles: (1) If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without his or her explicit, meaningful, and non-coerced consent; (2) No information regarding abnormal physical findings encountered on a medical student during a	Retain - still relevant

		physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent.	
295.131MSS	Equal Fees for Osteopathic and Allopathic Medical Students	AMA-MSS will ask the AMA to: (1) reaffirm AMA Policies H-405.989 and G-635.053; (2) discourage discrimination by institutions and programs based on Osteopathic or Allopathic training; (3) support equal fees for clinical rotation externships by Osteopathic and Allopathic medical students; and (4) encourage that LCME/ACGME accredited institutions maintain fair practice standards for equal access to all US medical students, Osteopathic and Allopathic.	Retain - still relevant
295.132MSS	Implementation of a Second Match	The AMA-MSS Governing Council will support measures to improve the Supplemental Offer and Acceptance Program (SOAP).~~will work collaboratively with the National Resident Matching Program (NRMP) to improve the scramble and study the logistics of a second Match.~~	Retain - still relevant; revised to say "support measures to improve the SOAP"
295.133MSS	Instruction of Effective Teaching Methods in Medical School Curricula	AMA-MSS will encourage the Liaison Committee on Medical Education to recommend that medical schools include instruction on effective teaching methods in their curricula.	Retain - still relevant
295.134MSS	Relocation of Medical Students in the Event of Emergency	AMA-MSS supports the formation of protocols by individual medical schools to relocate and temporarily or permanently assimilate medical students into other medical schools in the event of a crisis or natural disaster resulting in the closing of their medical school.	Retain - still relevant

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295.135MSS	Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine	AMA-MSS will ask the AMA to support the incorporation of Complementary and Alternative Medicine (CAM) in medical education as well as continuing medical education curricula, covering CAM's benefits, risks, and efficacy.	Retain - still relevant
295.136MSS	Combining the AOA and ACGME Resident Matching Programs	AMA-MSS will request that the NRMP explore the possibility of combining the AOA and the NRMP match and that the AMA-MSS await the report of the American Osteopathic Association House of Delegates on combining the AOA and NRMP match programs and continue to monitor the final actions of the various osteopathic governing bodies.	**Sunset - implemented**
295.137MSS	Expansion of Student Health Services	AMA-SS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center's hours to include weekend coverage.	Retain - still relevant
295.150MSS	USMLE Exam Fee Burden	AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students.	Retain - still relevant
295.151MSS	Including Elements of the Patient-Centered Medical Home Model in Medical Education	AMA-MSS encourages medical schools and residency programs to incorporate elements of the patient-centered medical home model, as defined by the AMA's Joint Principles of the Patient	Retain - still relevant

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		Centered Medical Home, into medical education.	
295.152MSS	Medical Student Access to Electronic Medical Records	AMA-MSS will ask the AMA to encourage teaching hospitals and other clinical clerkship sites to allow medical student access to patient electronic medical records.	Retain - still relevant
295.153MSS	Health Policy Education in Medical Schools	AMA-MSS will monitor progress on the development of the Association of American Medical College's behavioral and social science core competencies and report back upon release of these competencies.	Retain - still relevant
295.154MSS	Encouraging the Inclusion of Preclinical Longitudinal Clinical Experiences in the Medical Education Curriculum	AMA-MSS will ask the AMA to encourage medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education.	Retain - still relevant
295.155MSS	Global Health Education	AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning opportunities in their medical education curricula.	Retain - still relevant
295.156MSS	Medical School International Service Learning Opportunities	AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical schools international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and (2) work with the Association of American Medical Colleges, the American Association of Colleges of	Retain - still relevant

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		Osteopathic Medicine, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities.	
295.186MSS	Addressing Communication Deficits in Medical School Curricula	AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.	Retain - still relevant
305.038MSS	AMA-ERF Medical School Contributions	(1) AMA-MSS will ask the AMA to communicate to medical schools the importance of providing and annual accounting to state societies of how AMA Education and Research Foundation (AMA-ERF) funds are distributed. (2) AMA-MSS will encourage MSS chapters to assist the Alliance with the yearly fundraising efforts for AMA Education and Research Foundation (AMA-ERF) funds.	Retain - still relevant
305.058MSS	AMA-MSS Medical Student Loan & Financial Aid Online Education Resource	(1) AMA-MSS will ask the AMA to reaffirm AMA Policies ~~H-305.989 and~~ H-305.996. (2) AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures and any private loans the school may offer.	Retain - still relevant; removal of outdated policy
305.067MSS	Eligibility Criteria for AMA Foundation Scholarships	AMA-MSS will formally ask the AMA Foundation to consider allowing non-U.S. citizens attending U.S. medical schools to	Retain - still relevant

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		apply for AMA Foundation scholarships.	
310.002MSS	Parental ~~Maternity~~ Leave Benefits for House Staff	AMA-MSS will ask the AMA to support greater flexibility in residency training programs for parental ~~maternity~~ leave and alternative residency training schedules for pregnant house staff.	Retain - still relevant; amended to parental
310.004MSS	Shared Residencies	AMA-MSS will ask the AMA to: (1) support residency programs that currently offer shared residencies; and (2) encourage the establishment of such programs nationwide.	Retain - still relevant
310.041MSS	Improving Primary Care Residency Training to Advance Health Care for LGBTQ+ ~~Gay, Lesbian, Bisexual, and Transgender~~ Patients	AMA-MSS will ask the AMA to work with relevant stakeholders ~~the Accreditation Council for Graduate Medical Education and the American Osteopathic Association~~ to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for care for LGBTQ+ ~~gay, lesbian, bisexual, and transgender (GLBT)~~ pediatric patients.	Retain - still relevant; removed specific entities and expand to LGBTQ+
310.042MSS	Medical Student Position Regarding the 2010 ACGME Residency Work Standards	AMA-MSS: (1) supports programs focused on improving patient care with clear and measurable outcomes while paying equal attention to other initiatives that have been shown to minimize preventable medical errors and that the decision of whether to impose additional limitations on medical student, resident and fellow duty should be based on the prevailing evidence; (2) supports additional efforts to improve patient safety outside of limiting medical student, resident and fellow work hours, including more	Retain - still relevant

		adequate training in the art of transitioning care and identification of limitations due to sleep deprivation; and (3) supports supervision of medical students, residents and fellows that allows for competency based independence and delegation of clinical responsibility appropriate for level of training.	
310.051MSS	Standardizing the Residency Match System and Timeline	That our AMA-MSS study the reasons for ophthalmology and urology residencies using the non-NRMP match systems including reasons for non-participation in NRMP match system, and that our MSS report its findings by Interim 2015.	**Sunset - Report filed at I15.**
315.004MSS	Implementing the Use of EHR in Jail Health Services	AMA-MSS will ask the AMA to study the prevalence of and barriers to electronic health record utilization within corrections facilities.	Retain - still relevant
325.001MSS	Medical Specialty Information Brochures	AMA-MSS will ask the AMA to encourage all medical specialty societies to prepare informational brochures describing what a career in their medical field entails for medical students who are interested.	Retain - still relevant
345.001MSS	De-institutionalization of Mental Patients	AMA-MSS will ask the AMA to: (1) support the concept that the de-institutionalization of former psychiatric patients should be accompanied by adequate support from the community in the form of rehabilitation and counseling services; and (2) affirm the basic human rights of patients in board and care facilities to receive proper nutrition, essential medical care, adequate housing, community support, and to be permitted to	Retain - still relevant

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		participate in decisions regarding their environment.	
345.002MSS	An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses	AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students.	Retain - still relevant
345.003MSS	Improving Pediatric Mental Health Screening	AMA-MSS will ask the AMA to (1) recognize the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings.	Retain - still relevant
345.008MSS	Improving the Intersection Between Law Enforcement and the Mentally Ill	AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool 1) educating law enforcement officers about the mentally ill; 2) diverting mentally ill offenders from jails and prisons to medical treatment centers; and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports ~~the National Mental Health Alliance and~~ other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are	Retain - still relevant; strike specific entities

		designed to improve law enforcement's responses to the mentally ill.	
345.009MSS	Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools	AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis; 2) ensure anonymity, confidentiality, and protection from administration; 3) provide proactive intervention for identified at-risk students by mental health professionals; and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.	Retain - still relevant
350.003MSS	Minority Representation in the Medical Profession	AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.	Retain - still relevant
350.004MSS	Funding for Affirmative Action Programs	AMA-MSS will ask the AMA to: (1) support counseling and intervention designed to increase minority enrollment, retention, and graduation of medical students; and (2) support increased funding appropriations to DHHS Health Careers Opportunities Program.	Retain - still relevant
350.005MSS	The Disadvantaged Minority Health Improvement Act of 1989	AMA-MSS will ask the AMA to continue its efforts to increase the proportion of underrepresented minorities and women in medical schools and medical school faculties.	Retain - still relevant

350.011MSS	Continued Support for Diversity in Medical Education	AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.	Retain - still relevant
350.014MSS	Youth Health Pipeline Programs Initiative	AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with the local medical societies to develop pipeline programs that increase underrepresented in medicine (URM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical schools AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, Association of Native American Medical Students, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (URM) and disadvantaged students.	Retain - still relevant; included ANAMS
365.001MSS	Regulation of Occupational Carcinogens	AMA-MSS will ask the AMA to: (1) endorse the principle of using the best available scientific data	Retain - still relevant

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		including animal models as a basis for regulation of occupational carcinogens; and (2) urge OSHA to reinstate its regulation of carcinogens on the basis of best available scientific data including animal studies.	
370.005MSS	Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors	AMA-MSS will ask the AMA to support efforts to increase the number of all potential bone marrow donors, especially minority donors, registered in national bone marrow registries to improve the odds of successful HLA matching and bone marrow transplantation.	Retain - still relevant
370.015MSS	Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool	AMA-MSS will ask (1) that our AMA support the efforts of ~~the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other~~ relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation; (2) that our AMA support will-designed studies investigation the use of incentives, including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living decreased organ donation.	Retain - still relevant; strike out specific entities
370.016MSS	Targeted Education to Increase Organ Donation	AMA-MSS will ask that our AMA study potential educational efforts on the issue of organ donation tailored to	Retain - still relevant

		demographic groups with low organ donation rates.	
390.001MSS	Mandatory Assignment	AMA-MSS opposes mandatory assignment or any other pressure to accept claims on an assigned basis under Medicare in appropriate forums within the AMA.	Retain - still relevant
390.004MSS	Reimbursement Violations	AMA-MSS will ask the AMA to urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee for discussion and resolution.	Retain - still relevant
405.005MSS	Recognition for Community Service	AMA-MSS will continue to encourage medical student community service through policy promotion grants and other available means.	Retain - still relevant
420.003MSS	Nutrition Counseling for Pregnant and Recent Post-Partum Patients	AMA-MSS will ask the AMA to (1) support physician referrals of pregnant and recent post-partum patients to registered dietitians for nutrition counseling; and (2) advocate for the extension of health insurance coverage to registered dietician visits for all pregnant and recent post-partum patients.	Retain - still relevant
440.001MSS	Qualifications of the Surgeon General	AMA-MSS will ask the AMA to: (1) endorse the concept that the Surgeon General of the United States should have substantial experience or training in public health; and (2) oppose any nominations for the position of U.S. Surgeon General of persons without such background	Retain - still relevant
440.002MSS	Immunization Programs for Children	AMA-MSS will ask the AMA to: (1) support domestic and international immunization programs; (2) develop legislation	Retain - still relevant

		to ensure the priority of these programs; and (3) urge more intensive research to develop improved vaccines and immunization technology.	
440.004MSS	Education on the Harmful Effects of UVA and UVB Light	AMA-MSS will ask the AMA to assemble and disseminate information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers.	Retain - still relevant
440.006MSS	Ocular Sun Damage to the Retina and its Prevention	AMA-MSS will ask the AMA to: (1) support efforts to educate the general public about the potential long term effects of sun and bright light exposure, and the possible benefit derived from wearing protective eye wear blocking out radiation wavelengths of less than 500mm in preventing UV damage; and (2) incorporate this issue into existing health education efforts.	Retain - still relevant
440.007MSS	Lead Based Paints	AMA-MSS will ask the AMA to: (1) promote community awareness of the hazard of lead based paints; and (2) urge pain removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.	Retain - still relevant
440.025MSS	Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes	AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver's license who fail a vision screening at their respective Department of Motor Vehicles to an appropriate healthcare	Retain - still relevant

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		provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable.	
440.026MSS	Urging the Establishment of a Federal Office of Men's Health	AMA-MSS will ask the AMA to promote the establishment of a federal Office of Men's Health to coordinate outreach and awareness efforts on the federal and sate levels, promote preventive health behaviors for men, and provide a vehicle whereby researchers on men's health can collaborate and share information and findings.	Retain - still relevant
440.027MSS	Increasing Accessibility in Meningitis Protection	(1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate students about the benefits of vaccination. (2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance.	Retain - still relevant
440.051MSS	A Comprehensive Education Strategy to Improve Vaccination Rates	AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that under-immunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public	Retain - still relevant

		service announcement campaign aimed at increasing the vaccination rate.	
440.052MSS	Support for Municipal Ordinances the Promote Green Space in Residential Zoning Districts	AMA-MSS ask the AMA to support appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.	Retain - still relevant
440.053MSS	Support for Mandatory Vaccination	AMA-MSS (1) asks the AMA to reaffirm policy H-440.970; (2) encourages schools to report student vaccination rates and exemption rates to parents and guardians prior to annual student enrollment; and (3) supports the establishment of national vaccine requirements for minors.	Retain - still relevant
440.054MSS	Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes	AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities.	Retain - still relevant
440.055MSS	Oil and Gas Well-Stimulation Disclosure and Moratorium	AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction.	Retain - still relevant
440.056MSS	Radon Testing in Rentals	AMA-MSS will ask that our AMA support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease.	Retain - still relevant
445.003MSS	Sexually Exploitative Advertising to Physicians	AMA-MSS will ask the AMA to oppose the use of exploitative	Retain - still relevant

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		sexual themes in the marketing of medical products and technologies to physicians.	
450.002MSS	Eliminating Medical Tubing Misconnections	AMA-MSS supports the manufacture and use of medical tubing with designed incompatibility such that is physically impossible to connect tubing intending for different health functions.	Retain - still relevant
460.001MSS	Pure and Applied Research	AMA-MSS supports the following principles: (1) A commitment to stabilization of support for biomedical research and research training should be made by the government. (2) Private funding of academic research should be encouraged through a system of financial incentives. (3) The public's interest in a product of biotechnology, which it has substantially funded, should be protected even if commercial interests have funded the latter stages of the product's development. (4) In any system of regulation or incentive regarding private sponsorship of academic research, provisions should be made to actively encourage the role of training researchers as well as the role of conducting research. (5) Individuals and institutions must police themselves in order to combat overly restrictive regulation. (6) Greater decentralization of the decision-making authority from federal agencies to grantee institutions should occur, especially in the day-to-day management of grants and contracts. (7) Medical school admissions committees should develop criteria that do not penalize applicants who	Retain - still relevant

		express interest in pursuing careers in biomedical research. (8) Federal support for training physician-scientists should be strengthened. (9) Medical schools should make available adequate elective laboratory research experience in the basic science years for those students interested.	
460.002MSS	Biomedical Research & Research Training	AMA-MSS will apply its existing policy of support for biomedical research and research training by (1) continuing its support of the established peer review system whereby research funds are granted and (2) opposing any attempts to increase direct congressional control over specific allocation.	Retain - still relevant
460.004MSS	Human Genome Project	AMA-MSS will ask the AMA to: (1) endorse the scientific and medical objectives of the Human Genome Project; and (2) ask appropriate medical and scientific organizations to: (a) encourage worldwide support including monetary support, of advances in human genome research; (b) promote the free and open exchange of sequence information among nations; and (c) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind.	Retain - still relevant
460.012MSS	Encouraging Research into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients	AMA-MSS will ask the AMA to encourage research into the impact of long-term administration of hormone replacement therapy in transgender patients.	Retain - still relevant
460.013MSS	Medical Ghostwriting	AMA-MSS will ask the AMA to educate, at appropriate intervals, physicians and	Retain - still relevant

		physicians-in-training about the currently-defined differences between being an “author” and being a “contributor” as well as the varied potential for industry bias between these terms and the importance of self-identifying between these terms when submitting manuscripts for publication in accordance with the following text: (1) Authorship credit should be based on (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and (c) final approval of the version to be published. Authors should meet conditions all three conditions. Those meeting fewer than all three criteria should be considered contributors. (2) When a large, multicenter group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship/contributorship defined above and should complete journal-specific author and conflict-of-interest disclosure forms. When submitting a manuscript authored by a group, the corresponding author should clearly indicate the preferred citation and identify all individual authors as well as the group name. Journals generally list other members of the group in the Acknowledgments. The National Library of Medicine	

		indexes the group name and the names of individuals the group has identified as being directly responsible for the manuscript; it also lists the names of collaborators if they are listed in Acknowledgments. (3) Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship but rather, contributorship. (4) All persons designated as authors should qualify for authorship, and all those who qualify should be listed. (5) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.	
460.017MSS	Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials	AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; ~~(2) sign the petition titled "All Trials Registered, All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (2)~~ (2) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and ~~(4)~~ (3) encourage the expansion of clinical trial registrants to clinicaltrials.gov.	Retain - still relevant; strike (2) since AMA did sign petition
465.001MSS	Rural Health Opportunities for Medical Students	AMA-MSS will ask the AMA to encourage medical schools to develop Divisions of Rural Health within their Departments of Family Practice and encourage	Retain - still relevant

		rural physicians to help increase rural health opportunities for medical students by participation as members of the medical school academic environment.	
470.002MSS	Weight Loss in Interscholastic Wrestlers	AMA-MSS will ask the AMA to actively endorse efforts by state level high school athletic associations to establish programs that include enforceable guidelines concerning weight and body fat changes on a pre-competition basis for those sports in which weight management is a concern.	Retain - still relevant
470.004MSS	AMA Endorsement of National Bike to Work Day	AMA-MSS will the AMA to (1) support "National Bike to Work Day," and (2) encourage active transportation whenever possible.	Retain - still relevant
470.005MSS	Combating Childhood Obesity with Physical Education Requirements	AMA-MSS will ask the AMA to advocate that schools require a health care professional's recommendations for students to opt out of physical education programs, in order to stress the importance of physical wellness among children and to promote healthy lifestyle choices that extend into adulthood.	Retain - still relevant
470.008MSS	Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football	AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long-term consequences of traumatic brain injuries and concussions in the sport of football at all levels.	Retain - still relevant
480.001MSS	Medical Technology Assessment	AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic,	Retain - still relevant

		ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/ public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for	

		the assessment of medical technology.	
480.015MSS	Implementing Medication Reminder Systems	AMA-MSS will ask the AMA to support research into the efficacy of electronic reminder systems.	Retain - still relevant
485.001MSS	Television Broadcast of Sexual Encounters and Public Health Awareness	AMA-MSS will ask the AMA to urge television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.	Retain - still relevant
490.004MSS	Excise Cigarette Tax Bill for Medicare	AMA-MSS will ask the AMA to support a per package increase in the federal cigarette excise tax that would be aid directly to the Medicare Hospital Insurance Trust Fund.	Retain - still relevant
490.005MSS	"Smoke Free" Educational	AMA-MSS will ask the AMA to: (1) encourage departments of education, through state and local medical societies, to expand health education programs targeted at 12 to 18 years old; (2) urge state societies to promote the use of ~~the educational film "Death in the West," the educational program "Counseling Leadership About Smoking Pressure" (CLASP), and/or other~~ programs that have demonstrated reductions in tobacco use by young people; and (3) work with relevant stakeholders ~~the American Lung Association, American Heart Association, and the American Cancer Society~~ to develop a list of physicians recommended as speakers for local television and radio stations to discuss the ill	Retain -still relevant; strike out specifics

		effects of tobacco usage and to advocate a smoke-free society ~~by the year 2000.~~	
490.015MSS	Tobacco Cessation Counseling	AMA-MSS will ask the AMA to: (1) urge third party payors and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction.	Retain - still relevant
490.021MSS	Defining the Physical Boundaries and General Scope of Smoke-Free Policies on Medical Campuses and Other Institutions of Higher Education	AMA-MSS supports (1) the implementation of smoke-free policies on all medical campuses and institutions of higher education nationwide, wherein the geographic extent of the campus is defined as all buildings, facilities, grounds, and properties under the direct purview of the academic institutions (in short, all properties owned by the institution, including all transportation vehicles), providing enforcement of such policy does not interfere or conflict with state or federal law; (2) the enforcement of smoke-free policies at all institutions of higher education with the use of clearly displayed signs and placards, as well as the inclusion of information regarding the aforementioned policies in the institution's policy statements and bylaws; and (3) a set of comprehensive guidelines on which other academic	Retain - still relevant

		institutions should base their own smoke-free policies.	
490.002MSS	Federal Excise Tax for Tobacco Products	AMA-MSS will advocate for legislation establishing a federal excise tax on cigarettes such that the total cost of taxation of cigarettes will be indexed to the best available estimate of smoking-related health costs of a pack of cigarettes.	Retain - still relevant
500.003MSS	Tobacco Advertising Tax Deduction	AMA-MSS will ask the AMA to: (1) continue to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and (2) advocate that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion, and education.	Retain - still relevant
505.001MSS	Smoking on Commercial Aircraft	AMA-MSS will ask the AMA to urge the Civil Aeronautics Board to ban cigarette smoking on commercial aircraft.	Retain - still relevant
505.002MSS	Banning or Restricting Smoking in Public Places	AMA-MSS will ask the AMA to: (1) encourage and support efforts, legislative and otherwise, to ban or restrict smoking in all public places; (2) define "public places"; (3) ask that smoking be banned in public places where division into "smoking" and "no smoking" areas was not feasible; (4) ask that "no smoking" sections be large enough to accommodate the non-smokers who wish to utilize them; and (5) encourage that legislation in this area satisfy the four elements identified by the American Lung	Retain - still relevant

		Association as important in assuring effective anti-smoking legislation.	
505.006MSS	Smoking in Prisons	AMA-MSS will ask the AMA to: (1) support legislation banning smoking in prisons and jails; and (2) reaffirm its commitment to smoking cessation programs in correctional facilities.	Retain - still relevant
505.012MSS	National Legislation Banning Smoking in Food Establishments	AMA-MSS will and will ask the AMA to actively pursue national legislation banning smoking in all cafeterias, restaurants, cafes, coffee shops, food courts or concessions, supermarkets or retail food outlets, bars, taverns, or in a place where food or drink is sold to the public and consumed on the premise.	Retain - still relevant
515.001MSS	Identifying Victims of Adult Domestic Violence	AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence.	Retain - still relevant
515.002MSS	Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence	AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and support personnel providing legal medical services.	Retain - still relevant

515.003MSS	Screening Groups at High Risk for Homicide and Violent Injuries	AMA-MSS will ask the AMA to support the development and issuance of educational advisories, materials, and resources for physicians to assist them in identifying, counseling, and referring individuals at high risk of homicide or violent injury.	Retain - still relevant
515.004MSS	Gang Violence	AMA-MSS will ask the AMA to encourage the development of community-based programs that offer alternatives to gang membership.	Retain - still relevant
515.009MSS	Addressing Sexual Assault on College Campuses	AMA-MSS will ask our AMA support universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.	Retain - still relevant
520.001MSS	Doctor's Draft in Peacetime	AMA-MSS opposes the establishment of a doctors' draft in peacetime.	Retain - still relevant
520.002MSS	Opposition to Nuclear Weapons	AMA-MSS will ask the AMA to oppose the use of nuclear weapons and to support verified arms reduction on the part of all nations.	Retain - still relevant
520.004MSS	Nuclear, Biological, and Chemical Terrorism	AMA-MSS will ask the AMA to: (1) work with the appropriate agencies ~~(e.g. FEMA, DOD)~~ to support ongoing efforts for medical preparedness in the case of a nuclear, biological or chemical (NBC) emergency~~, including but not limited to terrorist action~~; and (2) consider what training is necessary regarding nuclear, biological, and chemical agent education for civilian medical schools and residency training programs.	Retain - still relevant; strike specifics

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520.005MSS	Ensuring High Quality Care for All Veterans and Their Families	Our AMA-MSS supports all avenues available to guarantee access to high quality health care for all eligible veterans and their families.	Retain - still relevant
530.003MSS	JAMA's Editorial Freedom	AMA-MSS (1) opposes the introduction of empowerment of a review board that would compromise JAMA's editorial freedom and independence; and (2) supports the concept that the editors of JAMA must have full authority for determining the editorial content of the journal.	Retain - still relevant
530.004MSS	Conference Registration Fees	AMA-MSS will encourage the AMA to offer, whenever feasible, a discounted registration fee not to exceed $100 to AMA student members for all AMA sponsored conferences of interest to medical student members.	Retain - still relevant
530.006MSS	Donation of Medical Journals	AMA-MSS will ask the AMA to support and encourage the donation of medical journals, under 5 years old, to non-profit organizations for distribution to the international medical communfity.	Retain - still relevant
530.024MSS	Medical Student Participation in Professional Organizations	AMA-MSS will ask the AMA to work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.	Retain - still relevant
535.001MSS	Commendation to the AMA Board of Trustees	AMA-MSS will ask the AMA to continue pursuing goals to health care cost containment.	Retain - still relevant
550.008MSS	Medical Student Regional Delegate Appointment	(1) AMA-MSS will ask the AMA to amend its bylaws such that Medical Student Regional Delegate (RD) and Medical Student Alternate Regional	Retain - still relevant

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		Delegate (AD) positions are allocated at a rate of one RD/AD for every 2,000 medical student members. These allocated RD/AD positions are then apportioned to the seven AMA-MSS Regions at a rate of one RD/AD per 2,000 medical student members within each region, with any remaining allocated RD/AD position(s) being apportioned to the Region(s) with the greatest number of medical student members in excess of a multiple of 2,000; and (2) AMA-MSS will amend its Internal Operating Procedures to reflect any amendments to the AMA Bylaws that affect the allocation or apportionment of Medical Student Regional Delegate and Medical Student Alternate Regional Delegate positions.	
565.001MSS	MSS Political Action	AMA-MSS encourages and will publicize the opportunity for student participation in AMPAC.	Retain - still relevant
565.002MSS	Preserving the AMA's Grassroots Legislative and Political Mission	AMA-MSS will ask the AMA to ensure that all Washington activities, including lobbying, political education, grassroots communications, and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner.	Retain - still relevant
630.007MSS	MSS Resolutions	It is the policy of the AMA-MSS that MSS resolutions, including the "whereas" and "resolve" clauses and footnotes, once submitted to the Medical Student Section ~~Department of~~	Retain - still relevant; amended name

		~~Medical Student Services~~ may not, with the exception of retyping, be altered by staff or an MSS council or committee prior to the MSS Assembly Meeting without the consent of the author.	
630.012MSS	Annual AMA-MSS Budget Statement	It is the policy of the AMA-MSS that (1) at the Annual meeting the Director of Medical Student Section ~~Services~~ shall provide the Assembly with a line-term budget for the current fiscal year; and (2) the Director of Medical Student Services will provide the AMA-MSS Governing Council with proposed budget statements at appropriate time during the year in order to facilitate planning and operations of the AMA-MSS.	Retain - still relevant; amended name
630.016MSS	MSS Reference Committee Information	AMA-MSS and the Office of Medical Student Section ~~Services~~ will release to state delegation chairperson or resolution author, a copy of the AMA-MSS Reference Committee Packet upon such request upon arrival at the AMA-MSS meeting.	Retain - still relevant; amended name
630.019MSS	MSS Master List of Dates	AMA-MSS will compile a yearly "Master List of Dates," which will identify important deadlines for MSS and AMA activities and programs which will be available at the Annual MSS Assembly.	Retain - still relevant
630.022MSS	Recycling at AMA-MSS Meetings	AMA-MSS urges the offices of the AMA to use recycled paper products whenever feasible in the production of student-related materials.	Retain - still relevant
630.025MSS	Changes in MSS Resolutions Forwarded to the AMA House of Delegates	It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House of Delegates (when they agree) may make grammatical or syntax changes in MSS	Retain - still relevant

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		resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution.	
630.029MSS	AMA Resource Libraries in Medical Schools	AMA-MSS urges its school delegates to obtain reserve space in their schools' medical libraries to set up an AMA library that would include, but not be limited to, the following documents: the AMA Policy Compendium; the state society Policy Compendium (where available); the most current AMA-HOD Proceedings; the most current AMA-MSS Proceedings; the AMA-MSS Textbook of Legislation; the AMA-MSS Resource Manual; the AMA-MSS Internal Policy and Digest of Actions; Chapter Bylaws; AMA-MSS Policy Documents (e.g. "Sexual Harassment Guidelines"); available national, state, regional, and county society updates and newsletters of at least the immediate past year; and AMA-MSS Program Modules.	Retain - still relevant
630.044MSS	Sunset Mechanism for AMA-MSS Policy	AMA-MSS will establish and use a sunset mechanism for AMA-	Retain - still relevant

		MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council; (2) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.	
630.055MSS	Alignment of MSS Resources with Strategic Priorities	The AMA-MSS Governing Council will evaluate the efficiency of MSS budget expenditures and resource allocations with respect to MSS strategic priorities.	Retain - still relevant
630.069MSS	Develop our Regions	(1) AMA-MSS reaffirms the roles of the Regional Chairs; (2) AMA-MSS recognizes that the roles of the Region are to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the chapters and states, and to facilitate interaction and integration of newly developing chapters with well-established chapters; (3) AMA-MSS recognizes the Regional	Retain - still relevant

		Leadership for their time, efforts and selflessness.	
640.003MSS	States Regional Chairs	AMA-MSS, through Regional Chairs will: (1) continue to encourage the development of AMA-MSS local sections ~~local MSS chapters~~ and state MSS sections in medical schools and states where they do not exist; (2) involve highly organized AMA-MSS local sections ~~MSS chapters~~ and state sections in providing organizational information and assistance to developing ~~chapters and~~ sections; (3) encourage ~~MSS chapters~~ AMA-MSS local sections to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs.	Retain - still relevant; updated to current language
640.008MSS	MSS Committee Reports	It is the policy of the AMA-MSS that the AMA-MSS Governing Council may suggest changes to committee reports but may not alter them without consultation with and agreement of the committee. Further, the Governing Council may include an addendum to the committee report, should a dissenting opinion exist, to distinguish the opinions of the Governing Council from those of the committee.	Retain - still relevant
640.013MSS	AMA-MSS Standing Committees	The AMA-MSS Governing Council will: (1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees ~~and report back at I-05~~; (2) handle requests for funding from	Retain - still relevant; strike out “and report back at I-05”

		MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council's goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per committee per year.	
645.001MSS	Use of the Term "Assembly"	AMA-MSS defines the term "Assembly" to refer to the group of voting members present at business meetings of the Medical Student Section.	Retain - still relevant
645.027MSS	A New Direction for the AMA-MSS Annual Meeting	AMA-MSS study the restructuring of the AMA-MSS Annual and Interim Meetings to meet the programming and policy needs of the AMA-MSS~~, and report back at A-11~~.	Retain - still relevant; strike out "report back at A-11"
650.001MSS	Coordination with the Resident and Fellow Section	AMA-MSS approves coordination of activities between the AMA-MSS Governing Council and the Resident and Fellow Section Governing Council, including the exchange of resolutions to be considered at the groups' respective meetings.	Retain - still relevant
655.001MSS	Student Membership in State Medical Societies	AMA-MSS will ask the AMA to: (1) support and encourage student membership and participation in state medical societies; to encourage societies to establish student dues that do not exceed 50 percent of the national student dues; and (2) seek the removal of any impediments to student membership in the AMA or in state or county medical societies.	Retain - still relevant
655.002MSS	Membership Recruitment Methods	AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free	Retain - still relevant

		membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA House of Delegates, AMA-MSS Digest of Policy Actions/ 176 with the goal of having a proportional number of delegate seats based on student membership.	
655.003MSS	Dual State Society Membership for Medical Students	The AMA-MSS Governing Council will ask the Department of Membership to encourage state medical societies to allow medical students to hold membership in the state society in which they attend medical school and also an associates membership in their state of permanent residence and that associate memberships in a state society not be counted in determining the number of AMA delegates representing a state.	Retain - still relevant
655.015MSS	Eligibility of Medical Students to Join the AMA while Enrolled in a Joint Degree Program	AMA-MSS will use peer-to-peer recruitment to identify and recruit, on an individual basis, joint degree students who begin their education in a discipline other than medicine.	Retain - still relevant

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655.024MSS	Improving Federated Membership Recruitment and Portability	AMA-MSS supports the development of a system whereby medical student, resident/fellow, and young physician members of the AMA, state, and county medical societies may rapidly transfer their new or existing memberships to the appropriate state and county medical societies of their new program or practice.	Retain - still relevant
660.026MSS	Councilor Selections	It is the policy of the AMA-MSS that AMA-MSS Governing Council members shall excuse themselves from all formal and informal Governing Council discussion and selection of any position for which they are candidates.	Retain - still relevant
665.012MSS	Evaluation of AMA-MSS Region Bylaws	It is the policy of the AMA-MSS: 1. That all Medical Student Region Bylaws include, at minimum, abbreviated versions of: a. The purpose of the Medical Student Region to elect Regional Delegates to the AMA House of Delegates per MSS IOP VIII. A; b. The responsibilities of the Region Chair per MSS IOP VIII. A. 3; c. An outline of the requirements for Regional Delegate Elections per MSS IOP VIII. B.2; d. Descriptions of their Regional Governing Council per MSS IOP VIII. A.4; and e. Determination and Responsibilities of the Regional Delegate Chair per MSS IOP VIII. C. 2. That all Medical Student Region Bylaws are in accordance with the prevailing parliamentary code of our AMA per MSS IOP XII.A.	Retain - still relevant; strike timeline

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		3. That the Speaker or Vice Speaker or his or her designee be authorized to correct article and section designations, punctuation and cross-references, and to make such other technical and conforming changes as may be necessary to reflect the intent of the MSS with respect to the Medical Student Region bylaws requirements as recommended by this report. 4. That our AMA-MSS reevaluate the content of each Medical Student Region's bylaws ~~and report back by A-17.~~	