Reference Committee D

BOT Report(s)

09 Bullying in the Practice of Medicine
10 Compassionate Release for Incarcerated Patients

Resolution(s)

401 Fatigue Mitigation Respite for Faculty and Residents
402 Air Quality and the Protection of Citizen Health
403 Support for Impairment Research
404 Early Vaccination for Correctional Workers and Incarcerated Persons
405 Attacking Disparities in COVID-19 Underlying Health Conditions
406 Face Masking in Hospitals During Flu Season
407* Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

**** contained in the Handbook Addendum***

REPORT 9 OF THE BOARD OF TRUSTEES (November 2020)
Bullying in the Practice of Medicine
(Reference Committee D)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting Resolution 402-A-19, "Bullying in the Practice of Medicine," was introduced by the Young Physicians Section and referred by the House of Delegates (HOD) for report back at the 2020 Annual Meeting. The resolution asks the American Medical Association (AMA) to help (1) establish a clear definition of professional bullying, (2) establish prevalence and impact of professional bullying, and (3) establish guidelines for prevention of professional bullying. This report provides statistics and other information about the prevalence and impact of professional bullying in the practice of medicine, and makes recommendations for the adoption of a formal definition and guidelines for establishing policies and strategies for preventing and addressing incidents of bullying among the health care staff.

Bullying in the practice of medicine for physicians can begin in medical school and can endure throughout a physician's career. Bullying is not limited to physicians and can happen among other members of the health care team. Bullying has many definitions, all commonly referring to the repeated abuse of a target by a perpetrator in a work setting. Bullying occurs at different levels within the practice of medicine, and affects the victim as well as their patients, care teams, organizations, and families. Nationally recognized organizations have established guidelines on which health care employers can base their internal policies, and many organizations have implemented anti-bullying or anti-violence policies. Bullying in medicine needs to be stopped and prevented for the sake of patients and care quality, the well-being of the physician workforce, and the integrity of the medical profession.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9, November 2020

Subject: Bullying in the Practice of Medicine (Resolution 402-A-19)

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee D

INTRODUCTION

At the 2019 Annual Meeting Resolution 402-A-19, "Bullying in the Practice of Medicine," was introduced by the Young Physicians Section and referred by the House of Delegates (HOD) for report back at the 2020 Annual Meeting. The resolution asks the American Medical Association (AMA) to: (1) help establish a clear definition of professional bullying; (2) establish prevalence and impact of professional bullying; and (3) establish guidelines for prevention of professional bullying.

This report provides statistics and other information about the causes, prevalence, and impact of bullying in the practice of medicine, and makes recommendations for the adoption of a formal definition and guidelines for establishing policies and strategies for preventing and addressing incidents of bullying among the health care staff.

BACKGROUND

Bullying in the medical profession is a well-documented issue involving the abuse of power or control over a person and repeated offensive, intimidating, malicious, or insulting behavior.[1-6] A 2017 Workplace Bullying Institute (WBI) survey showed 63 percent of workers are aware of bullying in their workplace.[7] Bullying in the workplace is more common than sexual harassment and is initiated by both men and women.[8] This report focuses on bullying among medical students, residents/fellows, and practicing physicians. However, it is important to note that other health care workers such as nurses, medical assistants, and pharmacists, as well as workers in other industries, can also be victims and perpetrators of workplace bullying. Organizational and health system factors may also contribute to the overall workplace climate or culture that allows unprofessional behavior, such as bullying, to persist. This report will discuss some of those factors and the importance of addressing bullying at the individual and organizational levels.

The effects of bullying in medicine can reach beyond the target to the patients, care teams, organizations, and the families of the patients and victims. The effects of bullying on the organizational culture and professional attitudes of the medical staff are significant and lasting, emphasizing the importance of changing the culture to address the problem.[9]

Calls for change in medical education to stop the abuse and harassment of medical students by their teachers have been vocalized for decades.[10] Yet, the unprofessional behavior exercised by some physicians, and the persistence of organizational cultures that enable the behavior, continue to degrade the medical profession. When patient safety, quality of care, and the overall health care industry are under increasingly high scrutiny, it is imperative that physicians, whose professional

aims include caring for others and as a unified group following a code of ethics, stop the cycle of bullying. Physicians and organizations together need to foster an educational and workplace culture that is respectful, supportive, and conducive to learning and providing high-quality care.

AMA POLICY

The AMA encourages all health care facilities to adopt policies to assess and manage reported workplace violence and abuse, and policies to reduce and prevent all forms of workplace violence and abuse. The AMA recommends that organizations develop a reporting tool that is easy for workers to find and complete and make training courses on workplace violence prevention available to employees and consultants (Policy H-515.966, "Violence and Abuse").

The AMA recommends that all medical education institutions 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, and 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 (Policy H-295.955, "Teacher-Learner Relationship In Medical Education").

AMA policy also states that the 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 (Policy H-215.978, "Workplace Violence Prevention").

DISCUSSION

Definitions of bullying

Several definitions of "bullying" are offered throughout existing literature. Various types of bullying have been studied, offering multiple bases on which to define the construct. The variation in definitions may hamper the ability to consistently identify and address the issue. An article in the *International Journal of Environmental Research and Public Health* states "bullying is commonly defined by its social manifestations, which are clearly classifiable under the same umbrella as aggressive behavior that generally occurs during interpersonal interactions in work settings. Similarly, there seems to be a consensus that bullying can be defined in terms of intentionality, frequency (e.g., weekly) or duration (e.g., approximately six months), the targets' reaction(s), perceived imbalance and misuse of power between the perpetrator and target, inadequate support, and the target's inability to defend himself from such aggression, as well as having to cope with

negative and constant social interactions, physical or verbal badgering, insulting remarks, and intense pressure."[11]

One study identified five categories of workplace violence:[12]

1. Threat to professional status (public humiliation)
2. Threat to personal standing (name calling, insults, teasing)
3. Isolation (withholding information)
4. Overwork (impossible deadlines)
5. Destabilization (failing to give credit where credit is due)

McAvoy et al. defined bullying as "persistent, offensive, abusive, intimidating, malicious, or insulting behavior; abuse of power; or unfair penal sanctions…that make the recipient feel upset, threatened, humiliated, or vulnerable, undermine their self-confidence and may cause them to suffer stress."[1] Bullying has also been referred to as disruptive, disrespectful, or aggressive behavior. The WBI, a U.S.-based organization dedicated to the eradication of workplace bullying, defines it as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. This definition is also used by The Joint Commission. It includes abusive conduct that is threatening, humiliating, or intimidating, as well as work interference and verbal abuse. The WBI also establishes that workplace bullying:[13]

- Is driven by perpetrators' need to control the targeted individual(s).
- Is initiated by bullies who choose their targets, timing, location, and methods.
- Is a set of acts of commission (doing things to others) or omission (withholding resources from others).
- Requires consequences for the targeted individual.
- Escalates to involve others who side with the bully, either voluntarily or through coercion.
- Undermines legitimate business interests when bullies' personal agendas take precedence over work itself.
- Is akin to domestic violence at work, where the abuser is on the payroll.

Workplace bullying has also been defined as "harassing, offending, or socially excluding someone or negatively affecting someone's work. In order for the label bullying…to be applied to a particular activity, interaction, or process, the bullying behavior has to occur repeatedly and regularly and over a period of time."[14]

A study published in *Innovations in Clinical Neuroscience* defines workplace bullying as "the repetitive and systematic engagement of interpersonally abusive behaviors that negatively affect both the targeted individual and the work organization."[15]

The Advisory, Conciliation and Arbitration Service describes bullying as "offensive, intimidating, malicious or insulting behavior, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual."

Harassment, while very similar to bullying and sometimes included in the definitions of bullying, should be distinguished for the purposes of this report. Workplace harassment has a legal definition and is prohibited by law in the context of certain protected classes. Harassment refers to cases in which enduring certain offensive conduct becomes a condition of continued employment, or cases

in which unwanted, unwelcomed and uninvited behavior is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. The law prohibits harassment based on race, sex, gender, ethnicity, disability, religion or sexual orientation.[16] Conversely, bullying has no legal definition and is not prohibited by law.

Considering the lack of legal definition, the number and variety of definitions in use, and the continued need for more universally accepted policies to prevent bullying in the workplace, the AMA Board of Trustees recommends the establishment of this inclusive, universal definition:

> Bullying is repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, threaten, undermine, or otherwise harm the target.

Causes and prevalence of bullying in health care professions

Research suggests that bullying results from a combination of individual (e.g., gender, age, and psychological characteristics), organizational (e.g., structure, job characteristics, team setting, etc.), and contextual (service-oriented roles, bureaucracy, public vs. private sector) factors.[11] The inherent desire of physicians to perform at a high level and gain the approval of their superiors, the stressful nature of the physician's role, and the organizational hierarchy in which they practice may create a perfect environment for workplace bullying.

Factors that contribute to workplace bullying include the following:[12]

- A bullying culture
- Poor staffing levels
- Excessive workloads
- Power imbalances
- Poor management skills
- Role conflict or ambiguity
- Stress
- Lack of autonomy

For physicians, bullying in the practice of medicine can begin in medical school. The majority of medical students report experiencing harassment or discrimination during their medical training.[2, 3] Medical students report being harassed or belittled by other students, residents, clinical professors, attending physicians, or patients.[2, 4, 17] Residents also report being bullied during their training, although the reports vary widely depending on the level of training and the country in which the study was completed.[5, 6] The most recent data shows nearly 14 percent of residents have experienced some type of bullying, defined broadly as "harassment that occurs repeatedly (more than once) by an individual in a position of greater power," since the beginning of their training.[6] Studies of practicing physicians in several countries demonstrate that bullying among physicians is a global issue.[11, 18-21]

Physicians and physician trainees are not the only perpetrators and victims of bullying in health care practices. Multiple studies show nurses also observe and experience bullying in their workplaces[22, 23], further pointing to organizational culture as a prime enabler of this type of conduct.

Effects of bullying in the workplace

Bullying in the workplace can have harsh and lasting effects on the victims, their colleagues and co-workers, and the organizations in which they work. Bullying can lead to negative personal or professional consequences including diminished professional satisfaction, unsatisfactory grades, decreased peer respect, social exclusion, distress, depression, anxiety, and burnout.[15] Physical and medical effects of bullying in the workplace include neck pain,[24] acute pain,[25] musculoskeletal complaints,[26] fibromyalgia,[27] and cardiovascular disease.[28] Studies also suggest workplace bullying is associated with subsequent suicidal ideation.[29, 30]

In the health care setting, individuals who reported being bullied experienced the following effects:[6]

- Feeling burned out—57 percent
- Worsened performance—39 percent
- Depression—27 percent
- Change in weight—15 percent
- Alcohol use—6 percent
- Improved performance—6 percent
- Left program—2 percent
- Illicit drug use—1 percent

Bullying among health care workers can also lead to numerous adverse effects for the organization.[11] The risk of adverse effects on patients is the subject of a 2008 Joint Commission alert that warns intimidating and disruptive behavior can result in medical error, poor patient satisfaction and preventable adverse outcomes.[31] Bullying can increase absenteeism[32], reduce overall quality and safety of care[23], and undermine an organization's attempts to foster a culture of respect and safety.[8, 31] Bullying in the health care workplace can threaten patient safety by diverting the worker's attention away from the patient and affecting the worker's ability to think clearly, making unsafe acts and errors more likely.[23] Furthermore, increased absenteeism, reduced quality and safety of care, reputational damage, legal costs, and employee turnover resulting from bullying can all have significant financial effects for an organization.[33]

Less discussed, but just as important, are the effects of workplace bullying on the physicians' family, which can involve withdrawal from family activities, emotional detachment from spouses and children, and sometimes domestic violence.[34]

Addressing bullying in medicine

In the United States bullying is not against the law and there are no universal protections in place for victims of bullying unless there is physical harm involved or if the victim is a member of a protected class, such as people of color or individuals with disabilities. The Healthy Workplace Bill, first introduced in California in 2003, is the product of a grassroots campaign that organized to end workplace bullying. To date, 30 state legislatures and two territories have introduced the bill or some form of it. Only three states have enacted laws similar to the Healthy Workplace Bill, 21 legislatures have considered but ultimately voted down similar bills, and six states currently have bills under review.[35] The bill in its original form protects employers from vicarious liability risk by requiring plaintiffs to provide proof of health harm and providing sufficient reason to terminate or sanction offenders. The bill also provides employees an avenue for legal redress, allows victims to sue the offender as an individual and seek restoration of lost wages and benefits, and holds the employer accountable, compelling them to prevent future instances.[35] The bill has been criticized

for overburdening employers with liability and opening the gates for frivolous complaints which would bog organizations down in expensive litigation.

The Occupational Safety and Health Administration (OSHA), part of the U.S. Department of Labor, ensures safe and healthful working conditions for U.S. workers by setting and enforcing standards and by providing training, outreach, education and assistance. OSHA provides guidance for employers in preventing and controlling workplace violence, which by their definition includes bullying, intimidation, and verbally abusive behaviors. OSHA does not have enforced standards for workplace violence; however, OSHA's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" provides a foundation for employers to build a workplace violence prevention program. The basic elements of a program should include:

1. Management commitment and employee participation
2. Worksite analysis
3. Hazard prevention and control
4. Safety and health training
5. Recordkeeping and program evaluation

OSHA's guidelines are comprehensive and should be considered integral in an organization's efforts to implement policies and procedures to prevent and address bullying in the workplace.

The Joint Commission has also published guidelines that provide actions organizations can take to effectively address disruptive and inappropriate behaviors in the workplace.[31]

1. "Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
    - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
    - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
    - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
    - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.
    - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).

4. Develop an organizational process for addressing intimidating and disruptive behaviors that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.
11. Document all attempts to address intimidating and disruptive behaviors."

Effective workplace policies

Addressing bullying in the practice of medicine requires acknowledgement of the problem and acceptance of responsibility by the industry, the local organization, and the individual professionals. Incidents of workplace violence, including bullying, may be underreported[36] but building the right culture within an organization can help overcome this. The director of the Vanderbilt Center for Patient & Professional Advocacy identifies two key steps for organizations to address bullying in the workplace:[37]

1. Make the administration aware that unprofessional behavior is a threat. If the team doesn't recognize that there is a problem, they won't have a plan to do something about it, nor recognize the threats to quality care.
2. Educate the entire staff—from physicians down to custodians-about why unprofessional—or hostile—behavior is a problem. If the staff recognizes that the leaders are concerned about bullying, they're more likely to come forward when they feel that bullying has occurred, or better yet, tell their co-worker that their behavior is inappropriate.

Health care organizations of all types and sizes should have some policy in place to prevent and address workplace violence, including bullying. A review of the OSHA and Joint Commission guidelines, in addition to existing codes of conduct and policies found online or provided directly

by organizations, reveals common elements for organizations to consider in developing policies. An effective workplace policy should:

- Describe the management's commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, administration, patients, contractors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for employees to take when they feel they are a victim of workplace bullying.
- Provide contact information and a clear process for a confidential means of documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements.

In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure, and confident in their roles and professions. Tactics to help create this type of organizational culture include:

- Surveying employees anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients.
- Showing employees their feedback is taken seriously by using the survey results to inform the development of programs and resources for employees, such as Employee Assistance Programs, that allow them a place to confidentially address experiences of bullying.
- Encouraging open discussions in which employees can talk freely about problems and/or encounters with behavior that may constitute bullying.
- Assessing situations and intervening as soon as reports are received (as is appropriate per policies) and enforcing consequences for perpetrators of bullying.
- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

CONCLUSION

Bullying in the workplace is a complex type of unprofessional conduct. Bullying in medicine happens as a result of a combination of individual, organizational, and systemic issues. The first line of defense against this destructive behavior are physicians, residents, and medical students. There is no justification for bullying, disrespect, harassment, intimidation, threats, or violence of any kind to occur among professionals whose primary purpose is to heal. Physicians choose medicine as their life's work for many reasons, one of the most important being their desire to help and care for people. Naturally, physicians want and deserve to be treated with respect and recognized as professionals, not "providers." Avoiding and working to prevent unprofessional behavior like bullying are worthwhile steps toward earning that respect and assuring medicine keeps its purpose. Correcting the issue can't be viewed as a physician-only problem, however. To effectively reduce bullying in the workplace, organizations should establish policies and procedures and implement programs and training to address the problem at all possible levels.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 402-A-19 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
   a. H-215.978, "Workplace Violence Prevention"
   b. H-295.955, "Teacher-Learner Relationship In Medical Education"
   c. H-515.966, "Violence and Abuse." (Reaffirm HOD Policy)

2. That our AMA define "workplace bullying" as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target. (New HOD Policy)

3. That our AMA adopt the following guidelines for the establishment of workplace policies to prevent and address bullying in the practice of medicine: (New HOD Policy)

   Health care organizations, including academic medical centers, should establish policies to prevent and address bullying in their workplaces. An effective workplace policy should:

   - Describe the management's commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
   - Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
   - Specify to whom the policy applies (i.e., medical staff, students, administration, patients, contractors, etc.).
   - Define both expected and prohibited behaviors.
   - Outline steps for individuals to take when they feel they are a victim of workplace bullying.
   - Provide contact information for a confidential means for documenting and reporting incidents.
   - Prohibit retaliation and ensure privacy and confidentiality.
   - Document training requirements and establish clear expectations about the training objectives.

   In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure and confident in their roles and professions. Tactics to help create this type of organizational culture include:

   - Surveying staff, and medical students in academic settings, anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients. Use the results to inform the development of programs and resources, showing the respondents that their feedback is taken seriously.
   - Encouraging open discussions in which staff can talk freely about problems and/or encounters with behavior that may constitute bullying.

- Establishing programs for staff and students, such as Employee Assistance Programs, that provide a place to confidentially address personal experiences of bullying.
- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

Fiscal Note: Minimal – Less than $500

REFERENCES

1. McAvoy BR, Murtagh J. Workplace bullying. *BMJ*. 2003;326(7393):776-7.
2. Frank E, Carrera JS, Stratton T, Bickel J, Nora LM. Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey. *BMJ*. 2006;333(7570):682-.
3. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med*. 2014;89(5):817-27.
4. Silver HK, Glicken AD. Medical student abuse. Incidence, severity, and significance. *JAMA*. 1990;263(4):527-32.
5. Ayyala MS, Chaudhry S, Windish D, Dupras D, Reddy ST, Wright SM. Awareness of Bullying in Residency: Results of a National Survey of Internal Medicine Program Directors. *J Grad Med Educ*. 2018;10(2):209-13.
6. Ayyala MS, Rios R, Wright SM. Perceived Bullying Among Internal Medicine Residents. *JAMA*. 2019;322(6):576-8.
7. Namie G. 2017 Workplace Bullying Institute U.S. Workplace Bullying Survey. Workplace Bullying Institute; 2017.
8. The Joint Commission. Bullying has no place in health care. 2016.
9. Tehrani N. Building a culture of respect: Managing bullying at work: CRC Press; 2003.
10. American Medical Association. BOT Report ZZ-I-90 Teacher-Learner Relationship in Medical Education. 1990.
11. Ariza-Montes A, Muniz NM, Montero-Simo MJ, Araque-Padilla RA. Workplace bullying among healthcare workers. *Int J Environ Res Public Health*. 2013;10(8):3121-39.
12. Pelligrini C. Workplace bullying is a real problem in health care. Bulletin of the American College of Surgeons. 2016.
13. Workplace Bullying Institute. The WBI Definition of Workplace Bullying 2019 [Available from: https://www.workplacebullying.org/individuals/problem/definition/.
14. Einarsen S, Hoel H, Zapf D, Cooper C. Bullying and harassment in the workplace: Developments in theory, research, and practice: CRC Press; 2010.
15. Sansone RA, Sansone LA. Workplace bullying: a tale of adverse consequences. *Innov Clin Neurosci*. 2015;12(1-2):32-7.
16. U.S. Equal Employment Opportunity Commission. Harassment 2020 [cited 2020 January 6]. Available from: https://www.eeoc.gov/laws/types/harassment.cfm.
17. Silver HK. Medical Students and Medical School. *JAMA*. 1982;247(3):309-10.
18. Workplace Bullying Among Family Physicians: A Gender Focused Study. *J Womens Health*. 2016;25(9):882-8.
19. Powell L. Bullying among doctors. *BMJ*. 2011;342:d2403.
20. Ekici D, Beder A. The effects of workplace bullying on physicians and nurses. *Aust J Adv Nurs*. 2014;31(4):24-33.
21. Rosta J, Aasland OG. Perceived bullying among Norwegian doctors in 1993, 2004 and 2014–2015: a study based on cross-sectional and repeated surveys. *BMJ Open*. 2018;8(2):e018161.
22. Esfahani AN, Shahbazi G. Workplace bullying in nursing: The case of Azerbaijan province, Iran. *Iran J Nurs Midwifery Res*. 2014;19(4):409-15.
23. Wallace SC, Gipson K. Bullying in Healthcare: A Disruptive Force Linked to Compromised Patient Safety. *Pa Pat Saf Advis*. 2017;14(2):64-70.
24. Kaaria S, Laaksonen M, Rahkonen O, Lahelma E, Leino-Arjas P. Risk factors of chronic neck pain: a prospective study among middle-aged employees. *Eur J Pain* (London, England). 2012;16(6):911-20.
25. Saastamoinen P, Laaksonen M, Leino-Arjas P, Lahelma E. Psychosocial risk factors of pain among employees. *Eur J Pain* (London, England). 2009;13(1):102-8.
26. Vie TL, Glaso L, Einarsen S. How does it feel? Workplace bullying, emotions and musculoskeletal complaints. *Scand J Psychol*. 2012;53(2):165-73.
27. Kivimaki M, Leino-Arjas P, Virtanen M, Elovainio M, Keltikangas-Jarvinen L, Puttonen S, et al. Work stress and incidence of newly diagnosed fibromyalgia: prospective cohort study. *J Psychosom Res*. 2004;57(5):417-22.

28. Kivimaki M, Virtanen M, Vartia M, Elovainio M, Vahtera J, Keltikangas-Jarvinen L. Workplace bullying and the risk of cardiovascular disease and depression. *Occup Environ Med*. 2003;60(10):779-83.
29. Nielsen MB, Nielsen GH, Notelaers G, Einarsen S. Workplace Bullying and Suicidal Ideation: A 3-Wave Longitudinal Norwegian Study. *Am J Public Health*. 2015;105(11):e23-e8.
30. Leach LS, Poyser C, Butterworth P. Workplace bullying and the association with suicidal ideation/thoughts and behaviour: a systematic review. *Occup Environ Med*. 2017;74(1):72-9.
31. The Joint Commission. Behaviors that undermine a culture of safety. 2008 July 9.
32. Kivimäki M, Elovainio M, Vahtera J. Workplace bullying and sickness absence in hospital staff. *Occup Environ Med*. 2000;57(10):656-60.
33. Fowler J. Financial Impacts of Workplace Bullying. Investopedia [Internet]. 2012 December 18, 2019. Available from: https://www.investopedia.com/financial-edge/0712/financial-impacts-of-workplace-bullying.aspx.
34. Workplace Bullying Institute. Impact of Workplace Bullying on Family 2019 [Available from: https://www.workplacebullying.org/individuals/impact/family/.
35. Healthy Workplace Bill [updated 2019. Available from: https://healthyworkplacebill.org/.
36. Arnetz JE, Hamblin L, Ager J, Luborsky M, Upfal MJ, Russell J, et al. Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. Workplace Health Saf. 2015;63(5):200-10.
37. HealthLeaders. Bullies Will Be Bullies. HealthLeaders [Internet]. 2008 February 20, 2020. Available from: https://www.healthleadersmedia.com/clinical-care/bullies-will-be-bullies.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10, November 2020

Subject:	Compassionate Release for Incarcerated Patients (Resolution 430-A-19)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

Resolution 430-A-19, introduced by the Medical Student Section and referred by the House of Delegates asked that:

> Our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BACKGROUND

Compassionate release, also known as medical release, is a program or policies that allow eligible, seriously ill prisoners early release or parole before sentence completion.[1] Compassionate release was authorized on the federal level under the Sentencing Reform Act of 1984 and subsequently adopted by 49 states and the District of Columbia.[2] Medical eligibility guidelines vary by jurisdiction, but most states require a terminal or severely debilitating medical condition, a condition that cannot be appropriately cared for within the prison, and a prisoner who poses no threat to society.[1]

Compassionate release is a matter of ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable.[3] In addition to ethical reasons, compassionate release has been called for to address the aging prison population, overcrowded facilities, increasing deaths in custody, and soaring medical costs of the criminal justice system.[1,4]

In 2016, a total of 6.6 million persons were involved in the US criminal justice system, including 1.5 million in state and federal prisons.[5] From 1993 to 2013, the population in state prisoners age 55-and-older more than tripled, increasing from 3 percent to 10 percent.[6] Between 2009 and 2013, the population of US federal prisoners aged 49 or younger decreased by 1 percent, whereas the number of prisoners aged 50 or older increased by 25 percent.[7]

Racial and ethnic minority groups are disproportionately represented in the justice-involved population. In 2017, blacks represented 12 percent of the US adult population but 33 percent of the sentenced prison population. Whites accounted for 64 percent of adults but 30 percent of prisoners. And while Hispanics represented 16 percent of the adult population, they accounted for 23 percent of inmates. From a health perspective, it is not uncommon for justice-involved individuals to

experience multiple chronic conditions, mental health disorders, and physical disabilities at relatively young ages.[9] They are also more likely to have experienced stress and trauma, have a substance use disorder, experienced homelessness, and have limited access to health care.[9]

EXISTING AMA POLICY

It is the AMA's position 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 D-430.997, "Support for Health Care Services to Incarcerated Persons"). The AMA supports of the National Commission on Correctional Health Care (NCCHC) standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities, and encourages all correctional systems to support NCCHC accreditation (D-430.997, "Support for Health Care Services to Incarcerated Persons").

The AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. The AMA encourages states to suspend rather than terminate Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. The AMA urges Congress, the Centers for Medicare & Medicaid Services, 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 to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism (Policy H-430.986, "Health Care While Incarcerated").

Furthermore, the AMA has urged the Society of Correctional Physicians and the NCCHC to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history (Policy H-280.948, "Long-Term Care Residents With Criminal Backgrounds "). The AMA does not have policy specific to compassionate release.

DISCUSSION

Compassionate release policies were authorized in recognition of the fact that appropriate care for patients with severe or debilitating illnesses is difficult, and sometimes impossible, to achieve in the correctional setting.[3,10,11] In 2013, the U.S. Department of Justice, Office of the Inspector General found that the Federal Bureau of Prisons (BOP's) compassionate release program was "poorly managed and implemented inconsistently," resulting in eligible inmates likely not being considered for release and terminally ill inmates dying before their requests were decided.[12] During a one year span in the BOP, only 85 (3.24 percent) out of 2,621 requests for compassionate release were granted.[12] State prison systems are likely to have similar rates of release, though only 13 states are required to track and report compassionate release statistics and few of them are required to make the information publicly available.[2]

Barriers to Implementing Compassionate Release Policies

The limited use of compassionate release is due to barriers at the patient, professional, policy, and administrative levels. At the patient level, individuals who are incarcerated may not be aware that they are eligible for compassionate release or incorrectly believe that they are ineligible. In a

survey of medically complex patients across three geographically disparate prisons and jails, 43 percent of respondents lacked the knowledge necessary to apply for compassionate release, and 75 percent indicated they would apply if eligible.[11,13]

At the policy level, both the medical eligibility criteria, based on medical evidence, and the administrative approval process, based on legal and correctional evidence, can limit the compassionate release process.[1] The federal criteria for a reduction in sentence for medical circumstances require either a terminal medical condition (a life expectancy of 18 months or less) or a debilitated medical condition (See Table 1). While some states have adopted the federal medical eligibility criteria, others have adopted their own criteria, resulting in variability in requirements across jurisdictions.

In determining medical eligibility, clinicians may have concerns about the legal consequences of releasing someone who lives beyond the expected timeframe since there are terminal illnesses with unpredictable trajectories.[4] Furthermore, the correctional evidence review process is often complex and time-consuming, requiring multiple layers of review.[2] A final decision may require approvals by the warden, a parole or review board, and even the state's governor.[10] These barriers can be compounded by administrative barriers such as objections by a victim advocate or prosecutor, concerns about public safety, and availability of post release community care plans to ensure placement in community hospice or return to the family home for care as well as arranging insurance coverage (i.e., applying for Medicaid coverage).[3, 10]

CONCLUSION

The use of compassionate release laws has been advocated for as a mechanism to address the growing number of older prisoners, overcrowding, increasing numbers of in-prison deaths, and the soaring medical costs of the criminal justice system, but also as a matter of medical ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable. While most jurisdictions have adopted laws authorizing compassionate release, this authority is being underutilized due to barriers at the patient, professional, policy and administrative levels. In order to increase the use of compassionate release policies, there needs to be better communication and education on these policies, not only to individuals who are incarcerated, but also to their families, correctional health care professionals, and parole board members.[11]

The medical profession plays a significant role in the compassionate release process in that physicians are required to determine medical eligibility for potential candidates. The eligibility criteria should be clear to clinicians and they should be comfortable determining if someone meets the criteria without fear of liability. The Board of Trustees recommends that the AMA collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release. This guidance can be shared with legislators and other relevant stakeholders once it is developed.

Finally, to ensure that compassionate release laws are being appropriately managed and implemented consistently, the AMA should support the transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 430-A-19 and the remainder of this report be filed.

Our American Medical Association supports policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

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

Table 1 - Federal Criteria for a Reduction in Sentence

Medical Circumstances	
Terminal Medical Condition	Inmates diagnosed with a terminal, incurable disease and whose life expectancy is 18 months or less, and/or has a disease or condition with an end-of-life trajectory under 18 USC § 3582(d)(1)
Debilitated Medical Condition	Inmates who have an incurable, progressive illness or who have suffered a debilitating injury from which they will never recover. If the inmate is: completely disabled, meaning the inmate cannot carry on any self-care and is totally confined to a bed or chair or capable of only limited self-acre and is confined to a bed or chair more than 50 percent of waking hours. Review should also include any cognitive deficits of the inmate. A cognitive deficit is not required in case of severe physical impairment, but may be a factor when considering the inmate's ability or inability to reoffend.

REFERENCES

1. Williams BA, Sudore RL, Greifinger R, et al. Balancing Punishment and Compassion for Seriously Ill Prisoners. *Ann Intern Med*. 2011; 155:122–126.
2. Families Against Mandatory Minimums. Everywhere and Nowhere: Compassionate Release in the States. Available at https://famm.org/our-work/compassionate-release/everywhere-and-nowhere/. Accessed March 2, 2020.
3. Mitchell A, Williams BA. Compassionate Release Policy Reform: Physicians as Advocates for Human Dignity. *AMA J Ethics*. 2017;19(9):854-861.
4. Bedard R., Metzger, L., and Williams, B. Ageing prisoners: An introduction to geriatric health-care challenges in correctional facilities. International Review of the Red Cross. 2017. Available at https://international-review.icrc.org/sites/default/files/irrc-903-12.pdf. Accessed March 2, 2020.
5. Carson, EA . Prisoners in 2016. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2018. https://www.bjs.gov/content/pub/pdf/p16.pdf. Accessed March 1, 2010.
6. Carson EA, Sabol WJ. Aging of the state prison population, 1993-2013. US Department of Justice Office of Justice Programs Bureau of Justice Statistics; May 2016. https://www.bjs.gov/content/pub/pdf/aspp9313.pdf. Accessed July 28, 2017.
7. Office of the Inspector General, The Impact of an Aging Inmate Population on the Federal Bureau of Prisons, DOJ, Washington, DC, February 2016, available at: https://oig.justice.gov/reports/2015/e1505.pdf.
8. Gramlich J. The gap between the number of blacks and whites in prison is shrinking Pew Research Center. April 30, 2019.Available at https://www.pewresearch.org/fact-tank/2019/04/30/shrinking-gap-between-number-of-blacks-and-whites-in-prison/. Accessed March 3, 2020.
9. Willians BA, Goodwin JS, Baillargeon J, et al. Addressing the Aging Crisis in U.S. Criminal Justice Health Care, *Journal of the American Geriatric Society*, Vol. 60, No. 6, 2012.
10. Linder JF, Meyers FJ. Palliative Care for Prison Inmates: "Don't Let Me Die in Prison". *JAMA*. 2007;298(8):894–901.
11. Prost SG and Williams BA. Strategies to Optimize the Use of Compassionate Release From US Prisons. *American Journal of Public Health*. 2020;110, S25-S26.
12. U.S. Department of Justice, Office of the Inspector General, The Federal Bureau of Prisons' Compassionate Release Program. April 2013. Available at https://oig.justice.gov/reports/2013/e1306.pdf. Accessed February 10, 2020.
13. Kanbergs A, Ahalt C, Cenzer IS, Morrison RS, Williams BA. "No one wants to die alone": incarcerated patients' knowledge and attitudes about early medical release. *J Pain Symptom Manage*. 2019;57(4):809–815.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(November 2020)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee D

Whereas, AMA Policy H-15.958, "Fatigue, Sleep Disorders, and Motor Vehicle Crashes," notes the risks associated with sleep deprivation and actions physicians can take to help protect patients; and

Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as shift work disorder;[5] and

Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property damage-only crashes;[2] and

Whereas, Physicians have a higher likelihood of dying from accidents than from other causes relative to the general populations;[4] and

Whereas, Physicians' risk of crashing while driving after working extended shifts (≥24 hours) was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional extended work shift hour;[3] and

Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night shift;[6] and

Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;[7] and

Whereas, Driving simulator studies show driving home from the night shift is associated with two to eight times the incidents of off track veering, decreased time to first accident, increased eye closure duration, and increased subjective sleepiness. Night-shift work increases driver drowsiness, degrading driving performance and increasing the risk of near-crash drive events;[8] and

Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift drives (43.8 percent) were terminated early for safety reasons, compared with zero near-crashes or early drive terminations during 16 post-sleep drives;[9] and

Whereas, Institutional support for self-care and fatigue mitigation can help protect physician well-being and model appropriate behaviors for physicians in training; therefore be it

RESOLVED, That our American Medical Association advocate for legislation and policies that support fatigue mitigation programs, which include, but are not limited to, a quiet place to rest or funding for alternative transport and return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working overnight or extended shifts. (Directive to Take Action)

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

Received: 09/30/20

References:
1. Fatigue Mitigation Transportation Reimbursement for Trainees. Available at https://medschool.ucla.edu/gme/transportation-reimbursement-for-fatigued-trainees.
2. Research on Drowsy Drive. Available at https://one.nhtsa.gov/Driving-Safety/Drowsy-Driving/scope%E2%80%93of%E2%80%93the%E2%80%93problem.
3. Barger LK, Cade BE, Ayas NT, Cronin JW, Rosner B, Speizer FE, et al. Extended work shifts and the risk of motor vehicle crashes among interns. N Engl J Med. 2005;352(2):125–34.
4. Frank, E, Biola, H, Burnett, CA. Mortality rates and causes among U.S. physicians. Am J Prev Med 2000; 19: 155–9.
5. Booker LA, Magee M, Rajaratnam SMW, Sletten TL, Howard ME. Individual vulnerability to insomnia, excessive sleepiness and shift work disorder amongst healthcare shift workers. A systematic review. Sleep Med Rev. 2018;41:220–33.
6. https://www.bbc.com/news/uk-england-suffolk-36767868
7. Williamson AM, Feyer AM. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. Occup Environ Med. 2000;57(10):649–655. doi:10.1136/oem.57.10.649.
8. Akerstedt T1, Peters B, Anund A, Kecklund G. Impaired alertness and performance driving home from the night shift: a driving simulator study. J Sleep Res. 2005 Mar;14(1):17-20.
9. Lee Ml1, Howard Me2, Horrey Wj3, Liang Y3, Anderson C4, Shreeve Ms5, O'brien Cs5, Czeisler Ca6. High Risk Of Near-Crash Driving Events Following Night-Shift Work.Proc Natl Acad Sci U S A. 2016 Jan 5;113(1):176-81. doi: 10.1073/pnas.1510383112.

RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

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.
Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(November 2020)

Introduced by: New York

Subject: Air Quality and the Protection of Citizen Health

Referred to: Reference Committee D

Whereas, The upper Hudson River, located in three counties of New York State has been the site of multiple pollution issues (Ciba-Geigy – Chromium and Cyanide in the Feeder Canal, GE – PCB in the Hudson River)[2,3;]; and

Whereas, The Wheelabrator Waste to Energy Plant and the Leigh Cement Facility are emitting over 300 pounds of heavy metals into the air each year for the last 25 years[4]; and

Whereas, Emission compliance is tested only every 30 months[5] and there is a history of violations to EPA guidelines[6]; and

Whereas, These metallic elements do not disappear from the environment, are considered systemic toxicants that are known to induce multiple organ damage, even at lower levels of exposure, and they are also classified as human carcinogens (known or probable) according to the U.S. Environmental Protection Agency, and the International Agency for Research on Cancer[7]; and

Whereas, Study of the potential ecological risks has revealed that the degree of ecological harm caused by heavy metal dust is very strong in both urban and suburban areas[8]; therefore be it

RESOLVED, That our American Medical Association review the Environmental Protection Agency's guidelines for monitoring the air quality which is emitted from smokestacks, taking into consideration the risks to citizens living downwind of smokestacks (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a report based on a review of the EPA's guidelines for monitoring air quality emitted from smokestacks ensuring that recommendations to protect the public's health are included in the report. (Directive to Take Action)

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

Received: 10/09/20

References:
1 Governor's Cancer Research Initiative – Warren County Cancer Incidence Report
2 https://www.epa.gov/hwcorrectiveactionsites/hazardous-waste-cleanup-ciba-geigy-hercules-plant-queensbury-glen-falls-new
3 https://www.epa.gov/enforcement/case-summary-ge-agrees-further-investigate-upper-hudson-river-floodplain-comprehensive
4 https://www.epa.gov/air-emissions-inventories/2014-national-emissions-inventory-nei-data
5 https://poststar.com/news/local/lehigh-cement-gets-state-ok-to-burn-paper-and-plastic/article_a6b97aeb-3a4e-58c4-a789-6188b82e13ae.html
6 https://www.adirondackalmanack.com/2019/12/epa-settles-with-glens-falls-lehigh-cement-co.html
7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144270/ Heavy Metals Toxicity and the Environment Paul B Tchounwouet al
8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5664660/ Int J Environ Res Public Health. 2017 Oct; 14(10): 1159.
9 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681084/pdf/40557_2015_Article_85.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(November 2020)

Introduced by: New York

Subject: Support for Impairment Research

Referred to: Reference Committee D

Whereas, There has been a proliferation of new and designer recreational drugs, most of which are difficult to detect; and

Whereas, One of the leading causes of motor vehicle operator (driver) impairment is fatigue without substance use or abuse; and

Whereas, There are no biochemical or physiological assays for fatigue, akin to breathalyzer readings for ethanol, leading to undercounting and under appreciation of its relevance; and

Whereas, Evidence is lacking for reliable and reproducible methods of impairment assessment unrelated to the few easily detectable intoxicants; and

Whereas, The United States Department of Defense (DOD), the Defense Advanced Research Projects Agency (DARPA), and the Institute of Medicine (IOM) have conducted extensive research on neurocognitive testing to assess alertness and impairment; therefore be it

RESOLVED, That our American Medical Association study the impairment of drivers and other operators of mechanized vehicles by substances, fatigue, medical or mental health conditions (Directive to Take Action); and be it further

RESOLVED, That this report include whether there are office or hospital-based methods to efficiently and effectively assess impairment of drivers with recommendations for further research that may be needed. (Directive to Take Action)

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

Received: 10/09/20

References:
1. Human Performance Under Sustained Operations
2. Identifying Cognitive State from Eye Metrics
3. NASA's Evidence Reports on Human Health Risks
4. Neurocognitive Monitors – Toward the Prevention of Cognitive Performance Decrements
5. Operational Neuroscience – Neurophysiological Measures in Applied Environments
6. Task Performance and Eye Activity – Predicting Behavior Relating to Cognitive Workload
7. World Anti-Doping Agency – Athlete Biological Passport Guidelines

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(November 2020)

Introduced by: American Association of Public Health Physicians

Subject: Early Vaccination for Correctional Workers and Incarcerated Persons

Referred to: Reference Committee D

Whereas, There are over 2 million persons incarcerated in the United States[1]; and

Whereas, There are approximately 750,000 persons working in correctional facilities, including many physicians and other health care professionals; and

Whereas, The incidence of SARS-CoV-2 in inmates is 3-5 times that of the general population[2,3]; and

Whereas, The COVID-19 death rate in inmates is 1.3 times that of the general population, even before adjusting for age[3]; and

Whereas, Correctional workers and inmates are located in a congregate setting, which is usually overcrowded by non-correctional standards, and where it is impossible to implement fully the CDC recommended COVID-19 precautions[4]; and

Whereas, More than 95% of inmates are released at some time[4]; and

Whereas, Correctional workers go home daily; and

Whereas, Correctional workers and released persons can transmit to the community any airborne infection that circulates in a correctional facility, including SARS-COV infection[5]; therefore be it

RESOLVED, That our American Medical Association advocate that conditions of incarceration in correctional facilities be improved to allow for the generally accepted CDC COVID-19 safety precautions to take place (Directive to Take Action); and be it further

RESOLVED, That our AMA support that inmates and correctional workers should be considered in a high-risk classification, along those other persons vulnerable for contacting and spreading COVID-19 infection (Directive to Take Action); and be it further

RESOLVED, That our AMA support the National Academies of Sciences, Engineering, and Medicine (NASEM) recommendation that correctional workers and incarcerated persons be considered in high risk groups and provided with a safe, effective, FDA-approved COVID-19 vaccine in Phase 1b (for those with comorbid and underlying conditions, including age and frailty) or Phase 2 (for all other correctional workers and incarcerated persons) of any vaccination campaign. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/14/20

References:
[1] Bureau of Justice Statistics, Correctional Populations in the United States, 2017-2018. https://www.bjs.gov/index.cfm?ty=pbdetail&iid=7026, accessed October 14, 2020.
[2] Jimenez MC et al. Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Netw Open*. 2020;3(8):e2018851. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769617, accessed October 14, 2020.
doi:10.1001/jamanetworkopen.2020.18851
[3] Saloner B et al. COVID-19 Cases and Deaths in Federal and State Prisons. *JAMA* 2020 Aug 11; 324(6):602-603. https://jamanetwork.com/journals/jama/fullarticle/2768249, accessed October 14, 2020.
[4] Rubin R. The Challenge of Preventing COVID-19 Spread in Correctional Facilities. *JAMA*. 2020 May 12;323(18):1760-1761. https://jamanetwork.com/journals/jama/fullarticle/2764379, accessed October 14, 2020.
[4] Bureau of Justice Statistics (Hughes T and Wilson DJ), Re-Entry Trends in the United States. https://www.bjs.gov/content/reentry/reentry.cfm, accessed October 14, 2020.
[5] Montoya-Barthelemy AG et al. COVID-19 and the Correctional Environment: The American Prison as a Focal Point for Public Health. *Am J Prev Med* 2020 Jun; 58(6):888-891. https://www.ajpmonline.org/article/S0749-3797(20)30144-6/fulltext, accessed October 14, 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(November 2020)

Introduced by: District of Columbia

Subject: Attacking Disparities in COVID-19 Underlying Health Conditions

Referred to: Reference Committee D

Whereas, COVID-19 mortality is much higher in individuals with obesity, diabetes, and hypertension, compared with those who do not have these conditions; and

Whereas, Racial disparities in the prevalence of these conditions contribute to disparities in COVID-19 mortality; and

Whereas, These health conditions can be rapidly improved by medical and nutritional interventions; and

Whereas, The Dietary Approaches to Stop Hypertension (DASH) study showed that a simple dietary intervention reduced blood pressure within two weeks; and

Whereas, In some cases, these conditions can be prevented by healthful diets, particularly plant-based diets; and

Whereas, While media attention has focused on reducing coronavirus transmission through personal hygiene, masks, and social distancing, there has been insufficient attention to the urgent need to address the underlying medical conditions, particularly obesity, diabetes, and hypertension, that make COVID-19 especially deadly; therefore be it

RESOLVED, That Our American Medical Association urge federal, state, and municipal leaders to prominently include in their COVID-19 public health advisories information on the role of underlying medical conditions in COVID-19 and in the role of nutrition, particularly plant-based diets, as well as physical activity, in addressing these conditions. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/14/20

RELEVANT AMA POLICY

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 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.
Citation: 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

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.
Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Obesity as a Major Health Concern H-440.902
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

Culturally Responsive Dietary and Nutritional Guidelines D-440.978

1. Our AMA and its Minority Affairs Section will: (a) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (b) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (c) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (d) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.

2.Our AMA will: (a) propose legislation that modifies the National School Lunch Act, 42 U.S.C. 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cows milk; and (b) recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individuals dietary needs.

Citation: BOT Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14; Modified: Res. 203, A-18

RELEVANT LITERATURE

Barrera FJ, Shekhar S, Wurth R, et al. Prevalence of diabetes and hypertension and their associated risks for poor outcomes in Covid-19 patients. J Endocr Soc. 2020 Jul 21;4(9):bvaa102. doi: 10.1210/jendso/bvaa102. eCollection 2020 Sep 1.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(November 2020)

Introduced by: Alma B. Littles, MD, Delegate

Subject: Face Masking in Hospitals During Flu Season

Referred to: Reference Committee D

Whereas, Studies of COVID-19 disease epidemiology during the SARS-CoV-2 pandemic clearly demonstrate that facial masks covering the mouth and nose decrease transmission of this disease; and

Whereas, Influenza viruses and the SARS-CoV-2 virus are of approximately the same size, yielding a logical conclusion that facial masks worn to blunt SARS-CoV-2 transmission should also decrease influenza transmission to a similar degree; and

Whereas, The populations of Australia (representative for Oceania), Chile (representative for South America) and South Africa (representative for Africa) have experienced extremely low rates of influenza during their recently concluded "flu" seasons of 2020[1], a time overlapping the SARS-CoV-2 pandemic and thus a time during which facial mask-wearing was being practiced by most of these nations' populations; and

Whereas, Similar trends of extremely low summer seasonal influenza rates have been observed in the United States during 2020[1]; and

Whereas, The precipitous decline of influenza activity worldwide has been attributed to widespread facial mask-wearing that has emerged to counter the SARS-CoV-2 pandemic[1]; and

Whereas, Influenza, like COVID-19, is a disease that most persons survive but also a disease that has caused thousands of premature deaths, ranging from about 12,000 to about 61,000 annually during the "influenza seasons" (approximately October 1 through March 31) of the past 10 years[2,3]; and

Whereas, During flu season, the death toll due to pneumonia, which in most cases is caused by a bacterial agent, is roughly three to five times larger than that due to influenza viruses[4]; and

Whereas, The death tolls of influenza and pneumonia fall disproportionately upon persons with multiple chronic illnesses or who are elderly (aged 65 or greater[5]), a demographic group that constitutes the majority of hospitalized patients; and

Whereas, It can therefore be anticipated that mandatory wearing of facial masks that cover the nose and mouth by patients, all hospital-based health care workers, and all hospital visitors during flu season should help greatly decrease transmission not only of influenza but also of pneumonia within hospitals, as has been observed in general regarding transmission of SARS-CoV-2; and

Whereas, Visitors to hospitalized patients, as well as physicians and hospital employees providing care to hospitalized patients during flu season may or may not have been immunized themselves against influenza and/or pneumonia; and

Whereas, Even immunized visitors, physicians or hospital employees may not have developed immunity to influenza, despite being immunized, because every year's influenza immunization effectiveness has fallen far short of 100% (being ~45% in 2019-20[6]; ~47% in 2018-19[7]; and ~36% in 2017-18[8]); and

Whereas, Unmasked physicians, nurses, other health care workers, other hospital employees and hospital visitors, as well as patients when in areas outside of their assigned bed or room, represent potential vectors for the transmission of influenza and pneumonia to other persons present within hospitals; and

Whereas, Hospital organizations should work to minimize any hospital-acquired disease transmission to their hospitalized patients, physicians, employees, and visitors; and

Whereas, Hospital organizations may fear a negative public relations consequence if they choose to require facial masks of all physicians, hospital employees, patients, and hospital visitors during flu season, partly because the wearing of facial masks has become a politicized matter,[9] despite voluminous scientific data on the topic that affirm the wisdom of such a requirement; and

Whereas, It is logical to therefore assert that a requirement for all hospital employees, physicians, and visitors to wear a facial mask may require imposition by a third-party accrediting organization in order to become enacted; and

Whereas, The Joint Commission is a third-party organization, which accredits the majority of US hospitals[10] and which has the power to strongly influence hospital and hospital system policies and procedures via its quasi-regulatory powers; and

Whereas, Other third-party organizations with similar powers also exist to accredit much smaller numbers of hospitals in the United States; therefore be it

RESOLVED, That our American Medical Association encourage The Joint Commission and other hospital accreditation organizations recognized by major insurers to stipulate that all hospitals require hospital employees, physicians, patients, and visitors to wear a facial mask that completely covers the mouth and nose while within hospital walls (unless they are consuming food while "socially distanced," or unless they are patients in their own rooms while "socially distanced") (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage publication of commentaries supportive of such regulations and standards in scientific journals and other publications (Directive to Take Action); and be it further

RESOLVED, That our AMA study the comparative disease-reduction effectiveness of various types of masks (N-95 masks versus "surgical" masks versus simple cloth facial coverings), toward potentially refining or making more specific any future mandates for facial coverings for persons while in-hospital as a visitor, patient or health care worker. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/14/20

References

1. https://www.cdc.gov/mmwr/volumes/69/wr/mm6937a6.htm?s_cid=mm6937a6_w Accessed September 19, 2020
2. https://www.cdc.gov/flu/about/burden/past-seasons.html Accessed July 17, 2020
3. https://www.cdc.gov/flu/about/season/flu-season.htm Accessed September 21, 2020
4. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview.pdf Accessed September 19, 2020
5. https://www.cdc.gov/flu/about/burden/2018-2019.html Accessed July 17, 2020
6. https://www.cdc.gov/mmwr/volumes/69/wr/mm6907a1.htm Accessed August 13, 2020
7. https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a2.htm Accessed August 13, 2020
8. https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a2.htm Accessed August 13, 2020
9. https://www.nbcnews.com/health/health-news/wearing-mask-has-become-politicized-science-says-it-shouldn-t-n1232604 Accessed August 13, 2020
10. Jha, AK. Accreditation, quality and making hospital care better. JAMA. 2018;320:2410-11

RELEVANT AMA POLICY

H-45.977, "Flu Protection Guidelines for Air Travel"

Our AMA supports the efforts of the Centers for Disease Control and Prevention to develop and disseminate guidelines on influenza and other contagious pathogens for all airline personnel and passengers.
(Sub. Res. 426, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

H-440.831, "Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization"

1. AMA policy is that, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues or threatens the availability of the health care workforce, particularly a disease that has the potential to become epidemic or pandemic, including influenza, and for which there is an available, safe, and effective vaccine, physicians, health care workers (HCWs), and family caregivers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician or HCW, appropriate protective measures should be taken.
2. Our AMA (a) encourages hospitals, health care systems, and health care providers to provide immunizations to HCWs against influenza and other highly transmissible diseases, at no cost to the employee, both for their own protection and to reduce the risk of infectious disease transmission to others; and (b) encourages health care institutions to develop mechanisms to maximize the rate of influenza immunization for HCWs, including the option of making immunization a condition of employment.
(Res. 8, A-15; Modified: CSAPH Rep. 1, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(November 2020)

Introduced by: American College of Preventive Medicine, American College of Occupational and Environmental Medicine, Aerospace Medical Association, American Association of Public Health Physicians, American Society of Addiction Medicine, Academy of Physicians in Clinical Research, Iowa

Subject: Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

Referred to: Reference Committee D

Whereas, The mission of our AMA is to promote the art and science of medicine and the betterment of public health; and

Whereas, The current AMA strategic focus areas include accelerating medical education, improving health outcomes, and enhancing professional satisfaction and practice sustainability; and

Whereas, All physicians have a responsibility to the health, safety and well-being of all citizens and their patients; and

Whereas, The COVID-19 pandemic has exposed many deficits in the infrastructure and funding of the US public health systems; and

Whereas, The current public health infrastructure was not prepared for the severity of this pandemic; and

Whereas, The public health infrastructure should provide all health care workers every protection to practice in a safe, healthy and effective manner; therefore be it

RESOLVED, That our American Medical Association champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/14/20