

Memo to: Delegates, Alternate Delegates
Executive Directors, Member Organizations of the House of Delegates

From: Bruce A. Scott, MD, Speaker, House of Delegates
Lisa Bohman Egbert, MD, Vice Speaker, House of Delegates

Date: May 21, 2021

Subject: Handbook Addendum - Supplemental Business and Information

We are pleased to provide the attached reports and resolutions that were received after the Delegates' Handbook resolution deadline:

BOT REPORTS

- 17 Specialty Society Representation in the House of Delegates - Five-Year Review
- 18 Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

CCB REPORTS

- 01 Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs
- 02 AMA Women Physicians Section: Clarification of Bylaw Language
- 03 Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

CEJA OPINIONS

- 01 Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"
- 02 Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians"

CEJA REPORTS

- 01 CEJA's Sunset Review of 2011 House Policies
- 02 Short-term Medical Service Trips
- 03 Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"
- 04 Augmented Intelligence & the Ethics of Innovation in Medicine
- 05 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

CLRPD REPORT

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership

CME REPORTS

- 01 Council on Medical Education Sunset Review of 2011 House Policies
- 02 Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses
- 03 Optimizing Match Outcomes
- 04 Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
- 05 Promising Practices Among Pathway Programs to Increase Diversity in Medicine

CMS REPORTS

- 01 Council on Medical Service's Sunset Review of 2011 House Policies
- 02 Continuity of Care for Patients Discharged from Hospital Settings
- 03 Universal Basic Income Pilot Studies
- 04 Promoting Accountability in Prior Authorization

- 05 Medical Center Patient Transfer Policies
- 06 Urgent Care Centers
- 07 Addressing Equity in Telehealth
- 08 Licensure and Telehealth
- 09 Addressing Payment in Delivery in Rural Hospitals

CSAPH REPORTS

- 01 Council on Science and Public Health Sunset Review of 2011 House Policies
- 02 Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings
- 03 Addressing Increases in Youth Suicide

CCB/CLRPD JOINT REPORT

- 01 CCB/CLRPD Joint Council Sunset Review of 2011 House Policies

RESOLUTIONS

- 003 Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions
- 004 AMA Resident/Fellow Councilor Term Limits
- 005 Resident and Fellow Access to Fertility Preservation
- 006 Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients
- 007 Nonconsensual Audio/Video Recording at Medical Encounters
- 008 Organ Transplant Equity for Persons with Disabilities
- 009 Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties
- 010 Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses
- 011 Truth, Reconciliation and Healing in Medicine and Medical Education
- 012 Increasing Public Umbilical Cord Blood Donations in Transplant Centers
- 013 Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 014 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 015 Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals
- 016 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 017 Improving the Health and Safety of Sex Workers
- 018 LGBTQ+ Representation in Medicine
- 019 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 020 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 021 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 107 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
- 108 Implant Associated Anaplastic Large Cell Lymphoma
- 109 Support for Universal Internet Access
- 110 Healthcare Marketplace Plan Selection
- 111 Towards Prevention of Hearing-Loss Associated Cognitive Impairment
- 112 Fertility Preservation Benefits for Active-Duty Military Personnel
- 113 Support for Universal Internet Access
- 114 Reimbursement of School-Based Health Centers
- 115 Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration
- 116 Caps on Insulin Co-Payments for Patients with Insurance
- 117 Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
- 206 Redefining the Definition of Harm
- 207 Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education
- 208 Increasing Residency Positions for Primary Care

- 209 Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research
- 210 Ransomware and Electronic Health Records
- 211 Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients
- 212 ONC's Information Blocking Regulations
- 213 CMMI Payment Reform Models
- 214 Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities
- 215 Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs
- 216 Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies
- 217 Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19
- 218 Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity
- 219 Oppose Tracking of People who Purchase Naloxone
- 220 Equal Access to Adoption for the LGBTQ Community
- 221 Support for Mental Health Courts
- 222 Advocating for the Amendment of Chronic Nuisance Ordinances
- 223 Supporting Collection of Data on Medical Repatriation
- 224 Using X-Ray and Dental Records for Assessing Immigrant Age
- 304 Decreasing Financial Burdens on Residents and Fellows
- 305 Non-Physician Post-Graduate Medical Training
- 306 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
- 307 Updating Current Wellness Policies and Improving Implementation
- 308 Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure
- 309 Supporting GME Program Child Care Residency Training
- 310 Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine
- 311 Student Loan Forgiveness
- 312 AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs
- 313 Fatigue Mitigation Respite for Faculty and Residents
- 314 Standard Procedure for Accommodations in USMLE and NBME Exams
- 315 Representation of Dermatological Pathologies in Varying Skin Tones
- 316 Improving Support and Access for Medical Students with Disabilities
- 403 Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America
- 404 Support for Safe and Equitable Access to Voting
- 405 Traumatic Brain Injury and Access to Firearms
- 406 Attacking Disparities in Covid-19 Underlying Health Conditions
- 407 Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities
- 408 Screening for HPV-Related Anal Cancer
- 409 Weapons in Correctional Healthcare Settings
- 410 Ensuring Adequate Health Care Resources to Address the Long COVID Crisis
- 411 Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens
- 412 Addressing Maternal Discrimination and Support for Flexible Family Leave
- 413 Call for Increased Funding and Research for Post Viral Syndromes
- 414 Call for Improved Personal Protective Equipment Design and Fitting
- 415 Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles
- 416 Expansion on Comprehensive Sexual Health Education

- 417 Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925
- 418 Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV
- 419 Student-Centered Approaches for Reforming School Disciplinary Policies
- 504 Healthy Air Quality
- 505 Personal Care Product Safety
- 506 Wireless Devices and Cell Tower Health and Safety
- 507 Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues
- 601 \$100 Member Annual Dues Payment Through 2023
- 602 Timely Promotion and Assistance in Advance Care Planning and Advance Directives
- 603 AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels
- 604 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
- 605 Amending G-630.140, Lodging, Meeting Venues and Social Functions
- 606 AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations
- 705 Improving the Prior Authorization Process
- 706 Prevent Medicare Advantage Plans from Limiting Care
- 707 Financial Incentives for Patients to Switch Treatments
- 708 Medicare Advantage Record Requests

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the 2020 June and November Special Meetings will be posted on the June 2021 Special Meeting website.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-JUN-21

Subject: Specialty Society Representation in the House of Delegates -
Five-Year Review

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) has completed its review of the specialty organizations and the
2 professional interest medical association seated in the House of Delegates (HOD) scheduled to
3 submit information and materials for the 2021 American Medical Association (AMA) Annual
4 Meeting in compliance with the five-year review process established by the House of Delegates in
5 Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty
6 Societies," Policy G-600.022 "Admission of Professional Interest Medical Associations to our
7 AMA House" and AMA Bylaw 8.5, "Periodic Review Process." Although the 2021 Annual
8 Meeting has been suspended by action of the Board of Trustees, to maintain a consistent review
9 process the Board completed this review to be presented at the June 2021 Special Meeting of the
10 House of Delegates.

11
12 Organizations are required to demonstrate continuing compliance with the guidelines established
13 for representation in the HOD. Compliance with the five responsibilities of national medical
14 specialty organizations and professional interest medical associations is also required as set out in
15 AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional
16 Interest Medical Associations."

17
18 The following organizations were reviewed for the 2021 Special Meeting:

19
20 AMDA – The Society for Post-Acute and Long-Term Care Medicine
21 American Academy of Child and Adolescent Psychiatry
22 American Association of Clinical Endocrinology
23 American Association of Physicians of Indian Origin
24 American College of Medical Genetics and Genomics
25 American College of Radiation Oncology
26 American Institute of Ultrasound in Medicine
27 American Orthopaedic Foot and Ankle Society
28 American Society for Clinical Pathology
29 American Society of Anesthesiologists
30 American Society of Cataract and Refractive Surgery
31 American Society of Colon and Rectal Surgeons
32 American Society of Dermatopathology
33 American Society of Neuroradiology
34 Obesity Medicine Association
35 Renal Physicians Association
36 Society of Critical Care Medicine
37 Society of Interventional Radiology

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society and professional medical interest association representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations and profession interest medical associations represented in the HOD.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX***Exhibit A - Summary Membership Information***

Organization	AMA Membership of Organization's Total Eligible Membership
AMDA – The Society for Post-Acute and Long-Term Care Medicine	564 of 2,561 (22%)
American Academy of Child and Adolescent Psychiatry	1,186 of 7,033 (17%)
American Association of Clinical Endocrinology	541 of 2,547 (21%)
American Association of Physicians of Indian Origin	1,687 of 12,049 (14%)
American College of Medical Genetics and Genomics	339 of 687 (49%)
American College of Radiation Oncology	267 of 724 (37%)
American Institute of Ultrasound in Medicine	918 of 4,406 (20%)
American Orthopaedic Foot and Ankle Society	212 of 889 (24%)
American Society for Clinical Pathology	1,948 of 7,584 (26%)
American Society of Anesthesiologists	7,001 of 44,293 (16%)
American Society of Cataract and Refractive Surgery	1,013 of 4,088 (25%)
American Society of Colon and Rectal Surgeons	685 of 2,738 (25%)
American Society of Dermatopathology	336 of 1,124 (30%)
American Society of Neuroradiology	1,017 of 4,771 (21%)
Obesity Medicine Association	402 of 1,959 (20%)
Renal Physicians Association	481 of 2,078 (23%)
Society of Critical Care Medicine	1,404 of 6,918 (20%)
Society of Interventional Radiology	679 of 3,271 (21%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies and Professional Interest Medical Associations (Policies G-600.020 and G-600.022)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

G-600.022

Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA.
2. The organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association).
3. The organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within the profession and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5. If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-JUN-21

Subject: Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

The COVID-19 pandemic has had devastating health consequences and caused widespread, serious disruption in the U.S. and worldwide. As of May 2021, there have been more than 32 million cases of COVID-19 in the U.S. and 576,238 COVID-19-related deaths. In 2020, the estimated age-adjusted death rate increased 15.9 percent compared with 2019 and COVID-19 was the underlying or a contributing cause of 377,883 deaths; COVID-19 death rates were highest among males, older adults, and American Indian/Alaska Native, Hispanic, and Black persons.¹ According to the National Center for Health Statistics, COVID-19 was the third leading underlying cause of death in 2020, replacing suicide as one of the leading causes of death.²

The use of vaccine credentialing and/or mandatory vaccination has been urged to speed the return to “normal.” Although existing AMA policy provides guidance on routine vaccinations, COVID-19 and COVID-19 vaccines present unique and challenging circumstances for which additional policy is needed.

DIGITAL VACCINATION CREDENTIAL SERVICES (DVCS)

With more people getting vaccinated and a strong desire from the public to return to “normal” life, many companies are developing digital vaccine credential services (DVCS), often referred to by the misnomer “vaccine passports.”¹ The term DVCS collectively refers to a digital vaccine credential issuer, a digital vaccine credential app/platform, or a digital vaccine credential requestor. A vaccine credential issuer refers to those who administer vaccines to individuals (e.g., physician offices, hospitals). A digital vaccine credential app/platform is the technology an individual would use to obtain a digital credential stating they have been vaccinated (i.e., a digital form of paper vaccination record). A digital vaccine credential requestor is any entity that seeks to view and possibly utilize the digital credential for some purpose (e.g., a sports venue that will only admit individuals who possess digital vaccine credentials).

Requiring proof of vaccination is not a novel concept in this country; for example, most jurisdictions require students to provide proof of vaccination prior to attending not only elementary and secondary schools, but also higher education and childcare facilities. Additionally, international travel often requires proof of vaccination against certain communicable diseases.

¹ AMA prefers the term “vaccine credential” to the frequently used “vaccine passport.” The latter is misleading and its purposes can be misunderstood. Passports are legal documents issued by nations to control entry and exit from a country and may also be used as legal identification. Vaccine credentials, in contrast, are medical documents that document an individual’s vaccination status. See Benjamin GC, *Vaccine Passports Are a Premature Solution to a Challenging Problem* (April 19, 2021) available at <https://leaps.org/vaccine-passports-are-a-premature-solution-to-a-challenging-problem/particle-1>.

Clearly these are specific use cases that do not apply to the country's entire population. DVCS, however, may be utilized by hundreds of millions of people across society depending on the scope of digital vaccine credential requestors planning to require digital vaccine credentials for entry into or participation in certain events, facilities, and venues, helping to reduce transmission and at the same time allowing participants to signal that they mutually share the protection of each having been vaccinated. Some envision DVCS potentially serving as a "critical driver for restoring baseline population health and promoting safe return to social, commercial, and leisure activities."³ There are already nearly 20 DVCS in development, and multiple states and other jurisdictions have developed their own DVCS.⁴

DVCS may provide multiple benefits that paper records do not. For example, paper records can be lost. They may also require individuals to make additional trips to physician offices or pharmacies to pick up copies of their vaccination records, which can be burdensome to both the patient and practice. Nor is it clear how individuals who received vaccine at mass vaccination events can obtain records after the event. Moreover, patients receive vaccinations at different stages throughout their lives. Additionally, paper vaccination records can be stolen or fraudulently produced—something already happening with COVID-19 vaccination cards.⁵ Accordingly, DVCS potentially serve as a reliable, convenient, and accurate mechanism by which one can demonstrate and verify their vaccination status. The DVCS seek to authentic vaccination status by providing a direct, electronic way to trace back where the information came from (a concept in health information technology known as provenance).

The use of DVCS is not without potential pitfalls, however. Some challenges are practical, such as ensuring that DVCS can successfully access source data stored in different formats, whether hardcopy or electronic, among the many entities that are providing COVID-19 vaccination. Significant questions remain around the ethics of DVCS usage, support, and mandates.⁶ Some states have or are attempting to ban the use of DVCS outright, reinforcing political divisions over COVID-19 vaccination.⁷ Even though the Biden administration has stated that it will not develop a federal DVCS, the AMA believes there is still an important role for the federal government to play in establishing, publicizing, and enforcing guidelines to which all DVCS must adhere.⁸

First, the use of DVCS must not outpace vaccine availability. Although supplies are rapidly increasing, vaccines are not yet universally accessible, particularly to individuals in historically marginalized and minoritized communities. Until all Americans are easily able to access vaccines and trusted DVCS, we must guard against programs that appear to confer special social privilege based on one's COVID-19 vaccination status. Additionally, the pandemic has demonstrated our country's stark disparities in access to technology, inequitable technology innovation and design priorities, and digital literacy. A DVCS must ensure that individuals can access their credentials in hard copy. Relatedly, both access to DVCS and DVCS functionality, content, and user interface must be designed with and for historically minoritized and marginalized communities. DVCS must address issues of culture, language, digital literacy, and access to broadband services to ensure that the tools are usable by all individuals and do not de facto discriminate.

Second, most of the digital vaccine credential apps/platforms individuals may use to obtain their digital vaccine credentials will not be subject to any sort of federal privacy protections (including the health sector specific privacy law, the Health Insurance Portability and Accountability Act of 1996 [HIPAA]). The AMA has advocated very strongly in recent years that the use of apps outside of HIPAA—despite their potential to improve individual access to one's own health information—pose a significant threat to the privacy of such information.⁹ Failure to address the lack of privacy requirements in apps can also stymie the uptake of innovative technologies that could potentially improve public health. Such failure, along with concern about surveillance, lack of coordination,

1 and distrust of technology companies contributed to sluggish adoption of digital contact-tracing
2 apps early in the pandemic.

3
4 Vaccine credentialing apps are likely to face similar concerns regarding privacy, surveillance, and
5 apprehension. Specifically, individuals subject to disproportionate rates of incarceration and
6 heightened surveillance based on immigration status or race; those with stigmatized health
7 conditions such as substance use disorder, HIV/AIDS, and other sexually transmitted infections;
8 LGBTQ individuals; unhoused people; and individuals with disabilities may be wary of DVCS due
9 to the possibility that third parties will share their data with employers, insurers, landlords, the
10 police, or other government agencies. Accordingly, the AMA recommended that the federal
11 government develop guidelines around data governance, including (but not limited to) utilization of
12 classic data privacy principles such as data minimization (i.e., only collecting the minimum amount
13 of information necessary to function as a credential), data sunset rules (i.e., discarding data once it
14 is no longer needed), and data sharing defaults that require users to opt-in to broader, automatic
15 data sharing (as opposed to forcing users to take additional steps to opt-out of such sharing).

16
17 Lastly, DVCS policy is likely to shift as vaccine availability increases and scientific evidence of
18 effectiveness or limitations grows.¹⁰ DVCS will need updates to accommodate these changing
19 requirements. No one organization, app marketplace, or industry will be able to track, monitor, and
20 provide individuals meaningful information on credentialing services, including data use policies
21 or app adherence to development principles. Individuals should have access to a single source of
22 truth where they can clearly understand features, functions, and the policies by which apps abide.
23 Accordingly, the AMA has recommended that DVCS register with the federal government after
24 meeting the above-described federal guidelines and be included on a public-facing list of all
25 registered DVCS along with clear and understandable information about each DVCS.

26 27 VACCINE MANDATES

28
29 As supplies of COVID-19 vaccines become available to meet demand vaccine hesitancy is high,
30 leading to doubt that the U.S. will be able to achieve “herd immunity,”¹¹ there have been calls for
31 mandating vaccination, especially for frontline health care workers, first responders, or others
32 considered essential workers, and students.¹² Mandates are legal and enforceable for interventions
33 that have been licensed by the U.S. Food and Drug Administration (FDA), but there are questions
34 about whether that is also the case for interventions released under an Emergency Use
35 Authorization (EUA), as COVID vaccines were initially.^{13,14} However, Pfizer/BioNTech recently
36 submitted a Biologics License Application (BLA) for their COVID-19 vaccine, asking for
37 expedited review and it is expected that FDA will soon grant a BLA.¹⁵

38
39 Vaccine mandates serve a fundamentally different purpose from DVCS: where DVCS offer
40 individuals opportunity to resume at least a semblance of “normal” activities in the absence of herd
41 immunity,¹⁶ mandates are promoted precisely as a means to achieve that immunity. The primary
42 intent of a mandate is to protect the health of the community, with benefit to the individual
43 secondary. Like DVCS, vaccine mandates raise concerns about equity, but given the different goal
44 to which they are directed, they do so in a somewhat different way. DVCS ease restrictions on
45 individuals but may unfairly exclude those who would choose to be vaccinated but cannot access
46 vaccine. Mandates intentionally impose restrictions by obviating personal choice and requiring
47 everyone to be vaccinated, with only limited exceptions, when voluntary uptake does not reach
48 levels that will achieve the public health goal of herd immunity. Importantly, privacy is less a
49 concern with respect to vaccine mandates than are issues of autonomy.

1 Historically, public health restrictions have been imposed on individual autonomy in the interest of
2 protecting the health of the community, and the legality of state-imposed vaccine mandates is well-
3 established. Since the landmark case *Jacobson v. Massachusetts* in 1905, the law has generally
4 favored states' ability to exercise the police power to compel vaccination "as the safety of the
5 general public may demand" even at the expense of individual liberty.¹⁷

6
7 All states currently employ vaccine mandates in some form, most in alignment with the
8 recommendations of the Centers for Disease Control and Prevention's (CDC's) Advisory
9 Committee on Immunization Practices (ACIP). As noted previously, all states require students to
10 provide proof of vaccination for specified vaccines before they are permitted to attend school.
11 Many require staff of health care institutions, public and private, to be vaccinated for a range of
12 infectious diseases, including seasonal influenza, to protect patients, staff, and the broader
13 community. All states permit medical exemptions for individuals who have contraindications for
14 vaccinations. Some allow parents or guardians to opt out of vaccination requirements if they object
15 on the basis of religious beliefs (44 states), or personal, moral, or other beliefs (15).

16
17 Mandates that allow non-medical exemptions are problematic. AMA policy supports eliminating
18 such exemptions, and further recommends that states have processes in place to determine which
19 vaccines will be mandatory for admission to school and other identified public venues and that
20 such mandates be based on ACIP recommendations.¹⁸ Policy also recognizes that health care
21 workers have strong obligations to accept vaccination voluntarily, particularly for vaccine
22 preventable diseases that are or may become epidemic or pandemic that pose significant medical
23 risk or threaten the availability of the health care workforce.¹⁹ AMA policy further encourages use
24 of mechanisms to encourage vaccine uptake, such as providing vaccination at no cost for
25 employees, up to and including making vaccination a condition of employment.²⁰

26
27 Research has demonstrated that vaccine mandates, and the elimination of non-medical exemptions
28 to those mandates, are effective at increasing immunization rates. COVID-19 vaccination is a
29 critical prevention measure to help end the COVID-19 pandemic. The three COVID-19 vaccines
30 currently authorized by the FDA for emergency use and recommended for use in the U.S.
31 population by the CDC as recommended by the ACIP have been shown to be effective against
32 SARS-CoV-2 infections, including the prevention of severe disease and death. According to the
33 CDC, as of May 7, 2021 about 45 percent of the total U.S. population have received one dose of
34 vaccine and about 33 percent have been fully vaccinated.²¹ However, the number of administered
35 vaccine doses is decreasing. There are currently five SARS-CoV-2 variants of concern circulating
36 for which there is evidence of an increase in transmissibility, more severe disease, significant
37 reduction in neutralization by antibodies generated during previous infection or vaccination,
38 reduced effectiveness of treatments or vaccines, or diagnostic detection failures.²²

39
40 Whether it is ethically acceptable for public or private entities to mandate vaccination as a
41 condition of access to employment; education; or other activities, goods, or services requires
42 thoughtful balancing of multiple considerations, including how readily the disease in question is
43 transmitted; what medical risk the disease represents for individuals and the community at large;
44 how risks of exposure are distributed across the population; the safety and efficacy of available
45 vaccine(s); the effectiveness and appropriateness of vaccination relative to other strategies for
46 preventing disease transmission; the medical value or possible contraindication of vaccination for
47 the individual; and the prevalence of the disease. The more readily transmissible a disease and the
48 greater the risk to those with whom an infected individual comes in contact relative to risks of
49 vaccination, the stronger the argument for mandatory vaccination. Given the high rate of
50 asymptomatic transmission in COVID-19, vaccinating the greatest number of individuals possible
51 is critical. Yet despite their effectiveness as public health tools, vaccine mandates are a blunt

1 instrument and may carry the risk of further eroding trust and ultimately undermining public health
2 goals.

3
4 Mandates are inherently coercive and have the potential to impose burdens unequally across
5 communities. For example, employer mandates that put livelihoods at risk may be especially
6 onerous in communities where opportunities for employment are limited. The COVID-19
7 pandemic has already had devastating effect among marginalized and minoritized communities for
8 individuals who have had no choice but to accept the risk of disease to preserve their livelihoods.
9 Moreover, mandating vaccination may further alienate individuals who are mistrustful of authority,
10 of vaccines generally, or of COVID-19 vaccines specifically even while it serves important public
11 health goals. They should therefore be implemented with these considerations in mind and efforts
12 made to minimize the potential to exacerbate existing inequities and adversely affect marginalized
13 and minoritized communities to the extent feasible.

14
15 If successful in increasing vaccine uptake, efforts to promote voluntary vaccination would better
16 respect recipients' autonomy and minimize the potential to impose disproportionate burdens on
17 marginalized and minoritized communities. For example, Maryland is now offering \$100 to state
18 employees who are fully vaccinated for COVID-19, while West Virginia is offering \$100 savings
19 bonds to young residents to get vaccinated and Connecticut is partnering with a restaurant trade
20 group to offer free drinks at certain restaurants for residents who have been vaccinated.²³ However,
21 data are not yet available to indicate whether such efforts might be effective in persuading enough
22 individuals to seek vaccination voluntarily that the U.S. could avoid the need to mandate
23 vaccination to control the spread of COVID-19.

24
25 With respect to health care professionals, guidance in the AMA Code of Medical Ethics provides
26 that physicians have a professional ethical responsibility to be vaccinated, absent medical
27 contraindications, and enjoins physicians who are not vaccinated for whatever reason to voluntarily
28 take steps to protect patients, fellow staff, and the public, including refraining from direct patient
29 contact.²⁴ Guidance further delineates the responsibilities of health care institutions to protect
30 patients and staff from epidemic or pandemic disease, such as providing and requiring use of
31 appropriate protective equipment and making vaccination readily available. Guidance recognizes
32 that this responsibility may extend to requiring staff to be vaccinated (absent medical
33 contraindication) when a safe, effective vaccine is available.

34 35 RECOMMENDATION

36
37 In light of the foregoing, the Board of Trustees recommends that the following be adopted and the
38 remainder of this report be filed:

39
40 COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our
41 AMA:

- 42
43 1. Encourages the development of clear, strong, universal, and enforceable federal guidelines
44 for the design and deployment of digital vaccination credentialing services (DVCS), and
45 that before decisions are taken to implement use of vaccine credentials
46 a. vaccine is widely accessible;
47 b. equity-centered privacy protections are in place to safeguard data collected from
48 individuals;
49 c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities;
50 and

- 1 d. credentials address the situation of individuals for whom vaccine is medically
2 contraindicated (New HOD Policy)
3
- 4 2. Recommends that decisions to mandate COVID-19 vaccination be made only:
5 a. After a vaccine has received full approval from the U.S. Food and Drug Administration
6 through a Biological Licenses Application;
7 b. In keeping with recommendations of the Advisory Committee on Immunization
8 Practices for use in the population subject to the mandate as approved by the Director
9 of the Centers for Disease Control and Prevention;
10 c. When individuals subject to the mandate have been given meaningful opportunity to
11 voluntarily accept vaccination; and
12 d. Implementation of the mandate minimizes the potential to exacerbate inequities or
13 adversely affect already marginalized or minoritized populations. (New HOD Policy)
14
- 15 3. Encourages the use of well-designed education and outreach efforts to promote vaccination
16 to protect both public health and public trust. (New HOD Policy)

Fiscal Note: Less than \$500.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-JUN-21

Subject: Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

During 2020, the five-year transition from dual accreditation entities acknowledged in the AMA Bylaws (ACGME for allopathic physicians and AOA for osteopathic physicians) to a single accreditation entity for all was completed. The ACGME now serves as the nation's sole accreditor for both osteopathic (DO) and allopathic (MD) residencies and fellowships.

The Council has prepared this report with appropriate bylaw amendments to ensure that the AMA Constitution and Bylaws remains an accurate document.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

- a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.
- b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
- c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

- 1 a) Members who are serving in fellowships approved by the Accreditation Council for
- 2 Graduate Medical Education ~~or the American Osteopathic Association.~~
- 3 b) Members who are serving, as their primary occupation, in a structured clinical,
- 4 educational, vocational, or research training program of at least six months to broaden
- 5 competency in a specialized field.
- 6

7 (Modify Bylaws)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-JUN-21

Subject: AMA Women Physicians Section: Clarification of Bylaw Language

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 In 2013, the Board of Trustees Women Physicians Advisory Committee transitioned to the Women
2 Physicians Section (WPS). The Council has worked closely with the WPS since its inception and
3 developed the existing bylaw language. The Council also has reviewed several iterations of the
4 WPS Internal Operating Procedures that were approved by the Board in 2013 and in 2017.

5
6 The IOP states that “all female physician and medical student members of the AMA as identified in
7 the AMA Masterfile are automatically enrolled in the WPS.” The IOP further provides the
8 opportunity for any other AMA member to opt-in as a WPS member. However, AMA Bylaw
9 7.10.1, states that “all female physicians and medical students who are active members of the AMA
10 shall be eligible to be members of the Women Physicians Section.” Per Bylaw 7.10.11, “Other
11 active AMA members who express an interest in women’s issues shall be eligible for WPS
12 membership.” The subtle distinction is that according to the Bylaws, all AMA member female
13 physicians and students are “eligible” to join, whereas the IOP includes them “automatically”. The
14 WPS Governing Council has asked the Council to consider proposing changes to Bylaw 7.10.1.

15
16 The WPS believes the IOP language better reflects the intent of the House when it created the
17 section and supports the existing practice of automatically enrolling all AMA member female
18 physicians as WPS members. The Council on Constitution and Bylaws concurs and presents this
19 report for House action.

20 21 RECOMMENDATIONS

22
23 The Council on Constitution and Bylaws recommends: 1) that the following amendments to the
24 AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the
25 affirmative vote of two-thirds of the members of the House of Delegates present and voting.

26
27 **7.10 Women Physicians Section.** The Women Physicians Section is a delineated Section.

28
29 **7.10.1 Membership.** All female physicians and medical students who are active
30 members of the AMA shall be ~~eligible to be~~ members of the Women
31 Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express
32 an interest in women’s issues shall be eligible to join the section. (Modify
33 Bylaws)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-JUN-21

Subject: Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The suspension of the 2020 Annual Meeting led to questions about eligibility for election within
2 the Young Physicians Section, and the Council on Ethical and Judicial Affairs suggested that the
3 Council on Constitution and Bylaws clarify the language of Bylaw 7.5.2 to more clearly explain
4 when a YPS governing council member's eligibility to remain in office. Per Bylaw 6.5.2.2, CEJA
5 has responsibility for interpreting the Constitution, Bylaws and rules of the AMA.

6
7 Bylaw 7.5.2 states: "If any officer or Governing Council member ceases to meet the membership
8 requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such
9 officer or member shall terminate and the position shall be declared vacant. If any officer's or
10 member's term would terminate prior to the conclusion of an Annual Meeting, such officer or
11 member shall be permitted to serve in office until the conclusion of the Annual Meeting in the
12 calendar year in which such officer or member ceases to meet the membership requirements of
13 Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA.
14 The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately
15 preceding provision of this section, the Immediate Past Chair shall be permitted to complete the
16 term of office even if the Immediate Past Chair is unable to continue to meet all of the membership
17 requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the
18 AMA."

19
20 Bylaw 7.5.1, defines YPS Membership as "All active physician members of the AMA who are not
21 resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of
22 professional practice after residency and fellowship training programs."

23
24 In preparing this report, the Council stresses that its intent is to clarify existing language consistent
25 with prior House action.

26 27 BACKGROUND

28
29 When the Young Physicians Section was established in 1986, YPS membership was defined as
30 physicians under the age of 40 or within the first five years of professional practice. The Bylaws at
31 that time stated that any physician who met the criteria for section membership was eligible to run
32 for office but would need to resign if for any reason the individual ceased to be a member of the
33 section. An additional provision provided specificity about how the chair-elect served a one-year
34 term, then automatically assumed the chair position for another year and ultimately moved into the
35 immediate past chair position for a total of 3 years of service. At all times, that individual was
36 required to meet the definition of young physician.

Over the ensuing years, the House adopted several bylaw amendments, notably:

- Language allowing the immediate past chair to serve even if he/she no longer is considered a young physician [CCB Report E, A-92]
- A grace period for governing council members (except the chair-elect) whose eligibility for YPS membership ends in the months preceding an Annual Meeting [CCB Report 4, I-03]
- Redefining a young physician as under age 40 or within the first 8 years of professional practice [CCB Report 2, A-07]

DISCUSSION

The current language of 7.5.2 dates from 1992 and is a bit confusing as it pertains to who can run for and hold the positions of chair-elect, chair and immediate past chair, which is what brought the issue to CEJA's attention.

Historical bylaw language stating that the chair-elect to immediate past chair progression entailed a total of 3 years of service was eliminated in 2006 when the Bylaws were simplified by consolidating many provisions and removing others from the Bylaws into individual section internal operating procedures [CCB Report 2, A-06]. Initially, the physician elected to the chair-elect position was required to meet the definition of 'young physician' for the entire 3-year term. Over time, the House provided an exemption for any chair (or other governing council member with the exception of the chair-elect) who reached the age of 40 or the maximum years in practice in the calendar year in which YPS elections occur to serve out the term. The House later added an additional grace provision to allow an immediate past chair to fulfill the 3-year commitment despite attaining age 40 or reaching the maximum years in practice.

Current Bylaw 7.5.2 as written and taken in accord with other bylaw language, which stipulates that all governing council members must be eligible for YPS section membership, prohibits a young physician from running for the chair-elect position if that individual will "age" or "term out" at any time during a chair-elect year, hence the wording "The preceding provision shall not apply to the Char-Elect." Other language ("If any officer's ... term would terminate prior to the conclusion of an Annual Meeting, such officer ... shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1..." allows the chair to serve a full year as YPS chair if the birthday or time in practice component of the eligibility criteria occurs between January and June. If, however, the birthday or years in practice occurs between June and year-end, the individual is not allowed to complete the term and must vacate the office. All chairs who complete the chair term may progress to the immediate past chair position regardless of age or time in practice, thus the language "Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA."

Several other bylaws impact the language of 7.5.2:

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section.

7.0.4 Officers. Each Section shall select a Chair and Vice Chair or Chair-Elect and other necessary and appropriate officers.

7.0.4.1 Qualifications. Officers of each Section must be members of the AMA and of the Section.

As requested by CEJA, the Council has developed the following amended bylaw language which it believes more clearly states the requirements:

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.5.2 Cessation of Eligibility of Governing Council Members. If any ~~officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw

7.5.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If any officer's or member's term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. The preceding provision shall not apply to the Chair Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

(Modify Bylaws)

Fiscal Note: Less than \$500

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE
COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-JUN-21

Subject: Joint Council Sunset Review of 2011 House Policies

Presented by: Madelyn E. Butler, MD, Chair, Council on Constitution and Bylaws
Shannon P. Pryor, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA councils and the House should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

1 The Councils on Constitution and Bylaws and Long Range Planning and Development
2 collaborated on this report, as they did the last time these policies were up for review and in the
3 context of a project to once again examine the sunset review process. The Councils welcome
4 feedback from the House on suggestions to improve the sunset review process.

5
6 The Councils note that there are several policies related to AMA elections due for sunset review in
7 2021, but these have been excluded as those policies are to be addressed by the Speakers' Task
8 Force on Election Reform.

9
10 RECOMMENDATION

11
12 The Councils on Constitution and Bylaws and Long Range Planning and Development
13 recommend that the House of Delegates policies that are listed in the appendix to this report be
14 acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
G-600.024	Representation of Medical Students and Residents in our AMA House	Our AMA supports the full participation of medical student and resident members of our AMA in the activities of the Association and in the policy processes of our AMA House of Delegates; and strongly encourages the delegation of each state association to have one resident delegate for each 1000 resident members of our AMA who are included in the base for determining the size of the state association's delegation.	Retain – this policy remains relevant.
G-600.090	Ancillary Meetings and Conferences of the House	The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates.	Retain – this policy remains relevant.
G-605.080	Board Meetings	The policies on Board meetings are as follows: (1) The House holds the Board accountable for the proper oversight of our AMA, but not through (a) the recording and publication of individual votes on matters before the Board, or (b) open meetings, because neither will enhance the Board's deliberations and may hinder the Board's decision-making process. (2) Any AMA member in good standing shall be allowed full access to AMA Board of Trustees meetings upon advance notification to the Chair of the Board unless issues of personnel or sensitive nature require an executive session.	Retain – this policy remains relevant.
G-615.002	AMA Member Component Groups	A "Section" is a formal group of physicians or medical students directly involved in policymaking through a delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Each Section will continue to have representation in the House of Delegates. There will be two types of Sections, fixed and delineated. "Fixed Sections" will represent the natural cycles related to a physician's career span. Since	Retain – this policy remains relevant.

		members of these groups would have limited opportunities for representation through their state/specialty's societies, the need for focused representation will be enduring. "Delineated Sections" will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented. These Sections will often be based on demographics or mode of practice. Delineated Sections will have a single delegate and alternate delegate in the HOD, and will operate under Internal Operating Procedures approved by the Board of Trustees. Delineated Sections will be reviewed every 5 years by the Council on Long Range Planning, which will make recommendations through the Board of Trustees to the House of Delegates, for renewal of the Section, based on criteria adopted by the House. The review provision allows for fluidity in the Association's structure as the activities and impact of the member groups are routinely evaluated. An "advisory committee" is an entity whose activities relate to education and advocacy. An advisory committee will have a governing council and a direct reporting relationship to the BOT. Advisory committees, however, will not have representation in the HOD. Advisory committees will operate under a charter that will be subject to review and renewal by the BOT at least every four years. An "ad hoc committee" is a special committee, workgroup, or taskforce appointed by the BOT, the Speaker of the House, or the House of Delegates. These committees will operate for a specific purpose and for a prescribed period of time. A "caucus" is an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD. With the exception of AMA Section caucuses, these groups will not have a reporting relationship or resources allocated by the AMA.	
G-615.040	Opinions and Reports of CEJA	AMA policy on opinions and reports of CEJA includes the following: (1) CEJA will inform the House of Delegates of an ethical Opinion adopted by the Council by presenting the Opinion to the House. The Council: (a) will identify the Opinion	Retain – this policy remains relevant.

		as informational; (b) may provide a description or discussion of the underlying facts and circumstances leading to the adoption of the ethical Opinion, and also an explanation of the Opinion and the reasons for its adoption by the Council. This explanatory material is neither the opinion of the Council nor policy of the Association; (c) will identify one or more Principles of Medical Ethics that form the basis for issuing the ethical Opinion; and (d) will provide the text of the ethical Opinion. (2) The House's process for considering opinions of CEJA may include the following elements: (a) Opinions of CEJA will be placed on the consent calendar for informational reports, but may be withdrawn from the consent calendar on motion of any member of the House of Delegates and referred to a Reference Committee. (b) The members of the House may discuss an ethical Opinion fully in Reference Committee and on the floor of the House. (c) After concluding its discussion, the House shall file the Opinion. (d) The House may adopt a resolution requesting CEJA to reconsider or withdraw the Opinion. CEJA shall respond to such a request in due course, after reconsidering the issues presented. The Opinion of CEJA that responds to such a request will be considered as informational, and therefore shall be filed. (3) Reports of CEJA which respond to requests from the House or which make recommendations to the House may be adopted, not adopted, or referred, as may be appropriate. A report may not be amended, except for amendments that clarify the meaning of the report and only with the concurrence of the Council.	
G-615.105	Employed Physicians and the AMA	1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. 2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review,	Retain – this policy remains relevant.

		economic credentialing, and the denial of due process. 3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.	
G-625.010	AMA Mission and Vision	Mission: To promote the art and science of medicine and the betterment of public health. Core Values: (1) Leadership; (2) Excellence; and (3) Integrity and Ethical Behavior. Vision: To be an essential part of the professional life of every physician.	Retain – this policy remains relevant.
G-630.010	Executive Vice President	The qualifications, roles and responsibilities of the Executive Vice President are as follows: (1) The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine who is an active member of our AMA at the time of his appointment and who possesses the necessary managerial qualifications. (2) The EVP shall clearly define and regularly evaluate roles and accountability of the corporate staff in adhering to clear guidelines on the limits of their decision-making authority and where to turn when confronted with issues beyond their scope of action: (a) The EVP should work with staff, the Board and the House to establish guidelines that differentiate between operational and policy issues, and identify to whom the staff should turn when they believe they are confronting an issue with policy implications. (b) These guidelines should be included both in the employee manual and a Board of Trustees Handbook. (c) These guidelines should be annually reviewed and updated, with the EVP leading the revision process. (d) Objectives in the performance appraisals of senior managers should be refocused to align with our AMA vision and bonus criteria should also be linked to the vision and the strategic plan. (e) Managers need to supervise work groups by establishing clear, measurable performance objectives and tasks for all staff and hold staff accountable. (3) The EVP shall evaluate staff structure and audit resources to ensure that our AMA is supported efficiently and effectively, consistent with the Strategic Plan approved by the House. As part of the evaluation of staff structure, the EVP should examine our AMA's member services strategy to ensure that the structure facilitates	Retain – this policy remains relevant.

		responsive and accurate responses to member queries. (4) Without suggesting that the current practice is or was in any way unauthorized, improper or illegal, the Executive Vice President will have the responsibility for hiring and firing the General Counsel following consultation with the Board of Trustees.	
G-630.021	Employment Agreements for Senior Executive Staff	Binding arbitration clauses should be contained in employment agreements for senior executive staff.	Retain – this policy remains relevant.
G-635.007	Electronic Application for Membership	1. Our AMA will provide all new online membership registrants with a post-transactional link to relevant state and county medical society web sites, where available. 2. Our AMA will implement a pre-transactional message and optional web site redirect mechanism to state society web sites for those medical students joining the AMA on-line from states with joint membership processing capabilities.	Retain – this policy remains relevant.
G-635.010	AMA Membership Strategy: General Approaches	Our AMA's general strategic approach on membership includes the following dimensions: (1) Our AMA and its component societies adopt the principle that membership value, as reflected in the physician's perception of quality relative to cost, drives the decision about membership. (2) Our AMA and its component societies adopt the principle that membership retention is as important an activity as recruitment, and that an organizational focus for those efforts should be developed. (3) The actions and directions of the Board of Trustees and Executive Vice President, with regard to membership recruitment, retention, and satisfaction, should become the top priorities of every AMA staff member, at all levels of the organization, and of all the Association's elected leadership. (4) Our AMA seeks innovative means to change its governance and structure to better align membership and representation for the purpose of meeting member needs and unifying the House of Medicine. (5) Our AMA will explore new avenues to increase member participation in the activities and governance of our AMA. (6) Our AMA shall continue to utilize pilot programs to measure the success of innovative membership recruitment and retention activities.	Retain – this policy remains relevant.

		(7) Our AMA will increase its staff and administrative efforts to become more of a local presence in the various regions of the United States.	
G-635.024	AMA Membership and Physicians on AMA Editorial Boards	Our AMA encourages all physicians serving on the editorial boards of AMA-published journals to become members of our AMA.	Retain – this policy remains relevant.
G-640.010	Guidelines for Representation of the AMA	Guidelines for the representation of our AMA include: (1) Our AMA directs that any individual who is publicly representing our AMA shall not present positions in conflict with established AMA policy; and (2) When appropriate, AMA public statements note that AMA policy is formulated by the House of Delegates, whose members represent approximately 90 percent of American physicians, even though a smaller percentage of eligible physicians are currently dues-paying members.	Retain – this policy remains relevant.
G-640.020	Political Action Committees and Contributions	Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.	Retain – this policy remains relevant.

G-620.060	Enhancing the Value of Membership in Organized Medicine	The perspective of our AMA House on enhancing the value of membership in organized medicine includes the following: (1) The House adopts the goal of improving Federation performance as a whole; (2) The House supports efforts <u>to improve the Federation's business processes by implementing a to improve the Federation's business processes by implementing to include a new member early recognition and retention system and consolidated billing and application process;</u> (3) The House supports the redesign of Federation products and pricing to increase overall appeal and thus recruit additional members and improve retention; (4) The House believes that the Federation should work together to leverage each organization's core competencies; (5) The House encourages the testing of different strategic and operational collaborative arrangements at many sites and the use of these to improve Federation membership, pricing, and member service; (6) The House encourages state medical associations and national medical specialty societies to review the composition of their AMA delegations; (7) The House believes it is important to promote resident physician membership in national medical specialty societies; (8) The House urges all county and state societies to implement a simple transfer of membership procedure to permit uninterrupted membership in organized medicine for physicians who relocate at any time during their careers, with such procedure containing the flexibility to permit resident AMA members to become regular state and county members through the transfer process; and (9) ~~G-635.023, AMA Support for the AMA Alliance~~ <u>Our AMA encourages its members to urge their spouses and their partners to become members of the AMA Alliance and their respective Alliances.</u> The House encourages medical associations and societies to support the membership efforts of the Alliance, particularly if dual membership billing is utilized, and, with the state and county associations, supports and acknowledges the efforts of our AMA Alliance and state and county medical alliances, whenever it is deemed possible and appropriate.	Retain as editorially amended [new member recognition and retention system has been accomplished] and consolidate with G-635.023

G-630.070	International Strategy	1. Our AMA recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship. ~~H-250.998~~—<u>2</u>. The AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations. ~~H-250.992~~—<u>3</u>. The AMA: (<u>1a</u>) continues to support the World Health Organization as an institution; (<u>2b</u>) advocates full funding as understood by the United States Government for the World Health Organization; (<u>3c</u>) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (<u>4d</u>) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. ~~H-250.999~~—<u>4</u>. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO. ~~H-250.991~~—<u>5</u>. The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. ~~H-250.993~~—<u>6</u>. The AMA will: (<u>1a</u>) continue to focus its international activities on and through organizations that are multinational in scope; (<u>2b</u>) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (<u>3c</u>) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (<u>4d</u>) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (<u>5e</u>) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for	Retain and consolidate with H-250.998, H-250.992 and H-250.991, H-250.993, H-250.986, H-250.999

		medical students, including appropriate learning objectives and assessment methods; and (6f) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives. ~~H-250.986—7.~~ Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.	
G-610.031	Creation of an AMA Election Reform Committee	Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.	Rescind – Task force members were appointed as directed; Speakers’ Report: Task Force on Election Reform was presented at I-19; and Election Task Force is assessing the entirety of our election process, with recommendations forthcoming.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-JUN-21

Subject: CEJA's Sunset Review of 2011 House Policies

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of
2 American Medical Association policies to ensure that our AMA's policy database is current,
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and
4 specifying the needed procedures:
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset
9 the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.
10
- 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies
13 that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to
14 the appropriate AMA councils for review; (c) Each AMA council that has been asked to review
15 policies shall develop and submit a report to the House of Delegates identifying policies that are
16 scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one
17 of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or
18 (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it
19 makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent
20 justification (f) The Speakers shall determine the best way for the House of Delegates to handle the
21 sunset reports.
22
- 23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or
25 has been accomplished.
26
- 27 4. The AMA councils and the House of Delegates should conform to the following guidelines for
28 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of
31 Delegates Reference Manual: Procedures, Policies and Practices.
32
- 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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

1 6. Sunset policies will be retained in the AMA historical archives.
2

3 RECOMMENDATION
4

5 The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that
6 are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of
7 this report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-140.980	Pending Federal Executions	Our AMA immediately inquire whether federal executions involve physicians, and if physicians are involved, that our AMA communicate to the federal government that such physician participation violates fundamental ethical standards of the medical profession and that other appropriate means be substituted that do not require physician participation. (Res. 9, A-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; still relevant but superseded by more recent policy: H-140.898 Medical Profession Opposition to Physician Participation in Execution; 9.7.3 Capital Punishment Code of Medical Ethics; D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols; H-140.963 Secrecy and Physician Participation in State Executions
D-315.988	Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry	Our AMA will (1) work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows: (a) implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements; (b) communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf; and (c) work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice; and ~~(2) assume a leadership position in both developing a~~ <u>Support continued updating of</u> Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct, ~~and in convening representatives from HIOs and the pharmaceutical companies to promulgate the adoption of the code of conduct in the use of prescribing data.~~ (BOT Rep. 24, I-04; Reaffirmed in lieu of Res. 624, A-05; Reaffirmation A-09; Reaffirmed: Res. 233, A-11)	Rescind in part. (1) Remains relevant (2) Remains relevant, though a guide for interaction has been developed (can be found here). Language amended as shown to reflect continued support of guidance.

D-350.991	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. (Res. 409, A-09; Appended: Res. 416, A-11)	Rescind in light of the dissolution of the Commission to End Health Care Disparities; initiatives of the newly launched Center for Health Equity, and; superseded by policies adopted in 2019 and 2020: H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice; D-350.981 Racial Essentialism in Medicine; H-65.952 Racism as a Public Health Threat; H-350.974 Racial and Ethnic Disparities in Health Care
D-435.995	Medical Care Online	Our AMA will educate physicians to be aware of clauses in their professional liability insurance coverage which may require them to report changes or additions to their practice-related activities, including the use or sponsorship of Web sites, e-mail, Internet discussion groups, and mailing lists. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
H-120.991	Sample Medications	Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge; (2) reiterates that samples of prescription drug products represent valuable benefits to the patients; (3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and (4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription	Retain; remains relevant

		drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples. (Sub. Res. 17, I-86; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: Res. 516, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-140.850	Exhibition of Plasticized Bodies Without Known Informed Consent	Our AMA will request that the United States or international authorities investigate if the bodies for the Premier Exhibition Inc. "Bodies Revealed" exhibits were obtained according to international human rights norms. (Res. 7, A-11)	Rescind; accomplished. Per June 2012 Implementation Chart: A letter signed by Dr. Madara was sent on September 22, 2011 requesting the Department of State - Bureau of Democracy, Human Rights, and Labor to participate in a thorough investigation of the manner in which plasticized remains have been obtained to assure that international human rights norms, including informed consent for the donation, have been followed.
H-140.901	Equity in Health Care for Domestic Partnerships	Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee. (Res. 101, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
H-140.964	Enforcement of Code of Ethics	It is the policy of the AMA (1) to make appropriate education and enforcement of its ethical guidelines a priority and (2) with the input and consent of the Federation, to begin a process to coordinate the Federation, including specialty societies and hospital medical staffs, in joint efforts to better communicate and enforce ethical standards. (BOT Rep. BBB, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-140.967	Conflicts of Interest	Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of	Retain; remains relevant.

		ethics. (CEJA Rep. G, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
H-245.969	Opposing Legal Prohibition of Circumcision	Our AMA will oppose any attempt to legally prohibit male infant circumcision. (Res. 222, I-11)	Rescind; more recent policy better captures the nuances of supporting male infant circumcision: H-60.945 Neonatal Male Circumcision, which reads: 1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions. 2. Our AMA encourages state

			Medicaid reimbursement of neonatal male circumcision.
H-275.976	Boundaries of Practice for Health Professionals	(1) The health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services required by an individual patient are provided by a professional whose basic competence and current performance are suited to render those services safely and effectively. In addition, patients also have a responsibility for maintaining coordination and continuity of their own health care. ~~(2) As a supplement to strengthen state licensure of health professionals, standard setting and self-regulatory competency assurance programs should be conducted by health professions associations, certifying and accrediting agencies, and health care facilities. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 8, A-11)~~	Retain in part. Retain (1); remains relevant. Rescind (2); superseded by more recent policy H-300.982 Maintaining Competence of Health Professionals, which reads in part: (1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such

			standards should be reviewed and revised periodically.
H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services: Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph. (Res. 8, A-11)	Retain; remains relevant.
H-350.972	Improving the Health of Black and Minority Populations	Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early	Retain; remains relevant.

		diagnosis. (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)	
H-375.984	<u>Participation in Peer Review</u>	Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: BOT Rep. 13, I-11)	Retain; remains relevant. Title amended for clarity of content.
H-375.989	Protection of Peer Review Records in Litigation	Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11)	Rescind; superseded by more recent and encompassing policy H-375.962 Legal Protections for Peer Review, particularly: Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

			Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.
H-375.993	Confidentiality in Medical Staff Peer Review	Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 13, I-11)	Rescind; superseded by more recent and encompassing policy H-375.962 Legal Protections for Peer Review, particularly: Composition of the Peer Review Committee Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.
H-375.997	Voluntary Medical Peer Review	Our AMA advocates the following principles for voluntary medical peer review: (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.	Retain; remains relevant.

		(2) Medical peer review should be a local process. (3) Physicians should be ultimately responsible for all peer review of medical care. (4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review. (5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care. (6) Any system of medical peer review should have established procedures. (7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation. (8) Peer review should be an educational process for physicians to assure quality medical services. (9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 5, I-10; Reaffirmed: BOT Rep. 13, I-11)	
H-405.978	Physicians with Communicable Diseases	Our AMA supports the development of general and specific recommendations relating to provision of patient care by physicians infected with communicable diseases of all types. (Res. 222, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant. This policy aligns with recently adopted policy on immunizations by physicians: 8.7 Routine Universal Immunization of Physicians, modified 2020, reads in part “Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and

			others. They must adjust their practice activities... including refraining from direct patient contact when appropriate.” H-440.831 Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization has similar language regarding practice adjustments.
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further 2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws. (Res. 7, I-11)	Retain; remains relevant.
H-440.946	Health Care Workers and HBV - Nonresponders to HBV Vaccine	It is the policy of the AMA that (1) health care workers who practice invasive procedures and who have been immunized with HBV vaccine be tested for evidence of immunity as determined by a protective anti-HBs level (as currently defined by the United States Public Health Service) one to six months after the completion of an immunization series; (2) such health care workers who fail to respond with an adequate anti-HBs level be counseled about their immune status, its possible impact on their careers, and offered a complete revaccination series; (3) health care workers given a revaccination series be tested again for an adequate anti-HBs level one to six months following the completion of the immunization series. Those who again fail to respond with a protective level should be counseled about the need to continue to follow universal precautions and the risk to their health if they continue to perform invasive procedures; and (4) health care workers be encouraged to maintain HBV immunity by obtaining	Rescind; purpose and intent covered in H-405.978 Physicians with Communicable Diseases.

		appropriate booster immunization when indicated. BOT Rep. X, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CEJA Rep. 8, A-11	
H-440.949	Immunity to Hepatitis B Virus	It is the policy of the AMA that a health care worker who is at risk for HBV infection, has no immunity resulting from a natural infection, and who has not initiated immunization with HBV vaccine, either be immunized or should abstain from performing invasive procedures. (BOT Rep. CCC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; purpose and intent covered in H-405.978 Physicians with Communicable Diseases.
H-460.906	Enhancing Patient Awareness of Research Participation	Our AMA: 1) will work with relevant health professional associations, patient groups, and the National Institutes of Health to encourage physicians to promote increased awareness among their patients, those who are healthy as well as those with specific diseases or conditions, of the societal and public health benefits of, and opportunities for, research participation; and 2) encourages physicians to participate in practice-based research initiatives and to enroll in practice-based research networks. (Res. 521, A-11)	Retain; remains relevant.
H-460.924	Race and Ethnicity as Variables in Medical Research	Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients. (CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by recent policy adopted at N-20. See H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, D-350.981 Racial Essentialism in Medicine

H-460.954	Researchers Lending Their Names as Co-authors of Laboratory Findings in Which They Did Not Participate	Our AMA condemns the practice of those persons who permit their names to be used as co-authors of papers publishing laboratory findings in which they did not participate, noting that persons who engage in such practice bear equal responsibility with those who are guilty of falsifying laboratory findings. Our AMA urges editors of scientific journals to reject for publication any paper reporting laboratory findings and research in which any person named as a co-author was not an active participant. (Res. 101, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-460.972	Fraud and Misrepresentation in Science	The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)	Retain; remains relevant.
H-5.988	Accurate Reporting on AMA Abortion Policy	Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA	Retain; remains relevant.

		policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy. (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
H-520.987	Condemning the Use of Children as Instruments of War	Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. (Res. 411, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-525.987	Surgical Modification of Female Genitalia	Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia. (Res. 13, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; superseded by more recent policy as outlined below: In re: infants and children with differences of sex development, see 2.2.1 Pediatric Decision Making , specifically (c) “Develop an individualized plan of care...in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become.” In re: female genital mutilation, see H-525.980 Expansion of AMA Policy on Female Genital Mutilation, which uses the FGM terminology (rather than broad language of “surgical modification” used in the policy at left). Last updated in 2017 it reads: Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the

			procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.
H-65.978	Nondiscrimination in Responding to Terrorism	Our AMA: (1) affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism. (Res. 1, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; remains relevant.
H-80.995	Evaluation of the Use of DNA Identification Testing in Criminal Proceedings	~~(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) appropriate control procedures to minimize the adverse effects of contamination and degradation; (b) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (c) the creation and use of population databases which accurately reflect the ethnic composition of~~	Rescind (1), (2) and (3); these have been accomplished by the Organization of Scientific Area Committees for Forensic Science who develop national forensic science

		~~populations amongst which matches might be sought.~~ ~~(2) The independent validation of each probe used for DNA identification testing should be conducted.~~ ~~(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.~~ ~~(4) DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files. (BOT Rep. FF, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)~~	standards and have published (2020) quality control guidelines that address degradation and DNA probes. The FBI has also published (2020) Quality Assurance Standards for Forensic DNA Testing Laboratories. Retain (4); remains relevant. Numbering removed and title amended as editorial edits.
H-90.987	Equal Access for ~~Physically Challenged~~ Physicians <u>with Physical Disabilities</u>	Our AMA supports equal access to all hospital facilities for ~~physically-challenged~~ physicians <u>with physical disabilities</u> as part of the Americans with Disabilities Act. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; remains relevant, with editorial changes in title and body to reflect person-first language.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-JUN-21

Subject: Short-term Medical Service Trips

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Short-term medical service trips, which send physicians and physicians in training from wealthier
2 countries to provide care in resource-limited settings abroad for a period of days or weeks, have
3 emerged as a prominent strategy for addressing global health inequities. They also provide training
4 and educational opportunities, thus offering benefit both to the communities that host them and the
5 medical professionals and trainees who volunteer their time and clinical skills. At the same time,
6 short-term medical service trips pose challenges for both volunteers and in prioritizing activities to
7 meet jointly defined goals; navigating day-to-day collaboration across differences of culture,
8 language, and history; and fairly allocating host and team resources in the local setting.

9
10 This report by the Council on Ethical and Judicial Affairs (CEJA) explores the phenomenon of
11 short-term medical service trips and offers guidance for physicians and physicians in training to
12 help them address the ethical challenges they face in providing clinical care in resource-limited
13 settings abroad.

14 15 THE APPEAL OF SERVING ABROAD

16
17 Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is
18 difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3
19 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically
20 related [11]. For trainees, in January 2015 the Consortium of Universities for Global Health
21 identified more than 180 websites relating to global health opportunities [2]. The Association of
22 American Medical Colleges found that among students who graduated in 2017–2018 between 25%
23 and 31% reported having had some “global health experience” during medical school [3].

24
25 A variety of reasons motivate physicians and trainees to volunteer for service trips. For many,
26 compelling motivations include the opportunities such trips offer to help address health inequities,
27 to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic
28 of study [11]. Service trips can also serve less lofty goals of building one's resume and improving
29 one's professional prospects, gaining the esteem of peers and family, or simply enjoying
30 international travel [1].

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

A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including “short-term medical volunteerism” [4], “short-term medical missions” [5], “short-term medical service trips” [6,7], “short-term experience in global health” [8,9], “global health field experience” [10], “global health experience,” and “international health experience” [1]. Each has merit as a term of art.

The Council on Ethical and Judicial Affairs prefers “short-term medical service trips.” In the council’s view, this term is clear, concrete, concise, and does not lend itself to multiple interpretations and possible misunderstanding. Importantly, it succinctly captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [9]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [8]. Many now also offer training opportunities for medical students and residents [8,9,10]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [8,9].

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are inherently vulnerable, “victims of social, economic, or environmental factors” who have limited access to health care [6]. As one observer noted, those who participate in short-term medical service trips and those who host them “can be characterized, respectively, as ‘people who travel easily and people who do not’” [9]. The latter also often lack access not only to health care, but to food, and economic and political power and “may feel unable to say no to charity in any form offered” [9].

The medical needs of host communities differ from those of volunteers’ home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by “conditions, such as severe malnutrition, for which medical volunteers may have limited experience” [6]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities of scarcity and vulnerability define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties not only to maximize and enhance good clinical outcomes, but also to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [8,1,9,10].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to

helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [8,6]. Trips should seek to balance community priorities with the training interests and abilities of participants [9], but in the first instance benefits should be those desired by the host community [8]. Likewise, interventions must be acceptable to the community [8].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [6]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [6,9].

Minimizing Potential for Harms & Burdens in Host Communities

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips could place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [8], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [8,10]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [6].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [10]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [10].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [8,1]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local “explanatory models” of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community [6,9,10].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [10], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities’ cultural and social traditions does *not* obligate physicians and trainees “to violate fundamental personal values, standards of medical care or ethical practice, or the law” [8]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [11]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [12].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip’s overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [8,1,9,10].

Prepare Diligently

Guidelines from the American College of Physicians recognize that “predeparture preparation is itself an ethical obligation” [8,cf. 1]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [10].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who have “training and/or familiarity with principles of international development, social determinants of health, and public health systems” [9].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs,

travel, malpractice insurance, and local credentialing requirements [6]. Equally important, to contribute effectively and minimize “culture shock” and distress, volunteers need a basic understanding of the context in which they will be working [1,6]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [6]. And they need to know whom they can turn to for guidance in the moment.

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real possibility for physicians and trainees that they will encounter situations in which they “are unable to act in ways that are consistent with ethics and their professional values” or “feel complicit in a moral wrong” [8]. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, by preference choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [8,9,10]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, which can promote dependence on the cycle of foreign charitable assistance rather than development of local infrastructure [9].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [8,6,9]. The measures used to evaluate program outcomes should be appropriate to the program’s goals as defined proactively in collaboration with the host community [8]; for example, some have suggested quality-adjusted life years (QALYs) [13]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [6]. Developing meaningful outcome measures will require thoughtful reflection on the knowledge and skills needed to address the specific situation of the community or communities being served and on what preparations are essential to maximize health benefits and avoid undue harm.

RECOMMENDATION

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

- (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.
- (b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.
- (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

- (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally
- (e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required

1 to provide acceptable safe, high quality care in the host setting. Team members should
2 practice only within the limits of their training and skills in keeping with the professional
3 standards of the sponsor's country.
4

5 (f) Put in place a mechanism to collect data on success in meeting collaboratively defined
6 goals for the trip in keeping with recognized standards for the conduct of health services
7 research and quality improvement activities in the sponsor's country.
8

9 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-JUN-21

Subject: Amendment to Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues”

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

In conjunction with the adoption of the modernized *Code of Medical Ethics* by the American Medical Association House of Delegates in June 2016, several stakeholders raised concerns that the Council on Ethical and Judicial Affairs’ (CEJA) guidance does not clearly distinguish being impaired from having a disability; does not acknowledge that not all illness or disability leads to impairment; and does not clearly address the fact that appropriate rehabilitation or accommodation can enable physicians who are impaired or who have a disability to practice safely.

The following report updates AMA ethics guidance to address these issues.

ILLNESS, DISABILITY & IMPAIRMENT

[Opinion 9.3.2](#) defines impairment as “[p]hysical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities...” The fact that a physician has a physical or mental health condition does not necessarily entail that the individual is also impaired. As the Federation of State Medical Boards (FSMB) has noted, “impairment is a functional classification” and that “the diagnosis of an illness does not equate with impairment” [1]. This distinction is fundamental to the goals of destigmatizing the conditions that can cause impairment and supporting physicians who become ill or have a disability but are nonetheless capable of safe and effective practice.

Disability leading to impairment has a broad range of meaning as it relates to the ability to practice medicine safely. A variety of physical and mental health conditions (including substance use or conditions related to aging), may result in cognitive or physical changes that can interfere with ability to practice safely. Among physicians, substance use disorder can also be a significant cause of impairment, with some studies showing rates as high as 21% [2]. And while physicians suffer many acute and chronic illness at similar rates to the general public, some illnesses, such as depression, occur with greater prevalence--medical residents, for example, experience depression at a rate of 15-30% compared to 7-8% in the general public [2]. Subtle changes in cognition or motor skills such as those associated with aging are difficult to identify and challenging to interpret with respect to their effect on ability to practice competently and safely. By contrast, sensory or physical disability (blindness, deafness, paraplegia) are often readily identifiable but do not necessarily impair safe practice in selected fields of medicine [1].

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

Screening and testing can be important for identifying physicians whose ability to practice at accepted professional standards is compromised by illness or disability. Some experts recommend a multi-pronged approach: mandatory testing before employment, random drug testing, evaluations after a sentinel event like a patient death or medical error, and establishment of uniform, national standards to encourage consistency across jurisdictions [3].

However, testing is not without its own challenges. For example, a seemingly straightforward drug test can produce false positive results in response to a legitimate or prescribed substance, and if handled improperly could “destroy a career” [3]. Further, not all testing produces a definitive result. Tests of cognitive or physical capacity may provide some data, but leave important questions unanswered, such as “When does ‘decline’ become ‘impairment’? And when does ‘impairment’ compromise safety?” [4]. Because impairment is a function of the nature of a physician’s practice, test results must be interpreted in context [5]. Screening and/or testing must be fair and thoughtfully implemented to avoid discrimination. Testing should also balance the need to detect impairment with physicians’ rights to privacy, autonomy, and due process [3].

RESPONDING TO IMPAIRMENT

Physicians’ fiduciary obligation to patients encompasses responsibilities to maintain their own physical and mental health [Opinion 9.3.1], to cultivate self-awareness as a dimension of professional competence [Opinion 8.13], and a responsibility to respond when they believe a colleague is impaired to the extent patients are at risk, in keeping with the profession’s overarching duty of self-regulation. These obligations are grounded in the principle that physicians “uphold standards of professionalism” in part by responding to other physicians who are “deficient in character or competence” [Principle II].

Seeking & Offering Assistance

Physicians’ responsibility for self-awareness requires that they be sensitive to factors that affect their ability to provide appropriate care, one of which is their own health status. When they become aware that a physical or mental health condition may be interfering with their ability to provide sound patient care, they have a responsibility to address the problem, by consulting their personal physician or seeking other assistance. As CEJA has noted elsewhere,

Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation [CEJA Report 1-I-19].

Physicians are professionally responsible to one another and thus have an obligation to respond when a colleague appears to be unable to practice safely. They should intervene with respect and compassion to ensure, first, that the individual no longer endangers patients, and second, that the individual receives appropriate evaluation and care to treat any impairing condition.

Intervention

Ultimately, physicians have an ethical duty to act when colleagues continue to practice unsafely despite efforts to dissuade them, including reporting where appropriate and needed. This responsibility derives from the obligation of self-regulation, a central element of the medical

profession's contract with society to establish and uphold standards of competence and conduct for safe, ethical and effective patient care" [6] In some situations, physicians may have a legal duty to report colleagues whom they believe may be impaired [7].

A host of factors can complicate the duty to report, including not only uncertainty about whether impairment is actually present, but also denial, stigmatization, concerns about practice coverage, and fear of retaliation (especially when reporting a superior) [7]. Health care institutions and state medical boards should offer education and training to help physicians be more effective and comfortable with detecting impairment in the workplace. Fostering an environment where physicians know what to look for and feel comfortable reporting helps protect the well-being of all parties involved. Early detection mitigates harm by catching an impairment before it worsens and creates a less safe practice environment over time [4].

ACCOMMODATING DISABILITY

The 1990 Americans with Disabilities Act (ADA) ushered in a new era of legal protections and rights for people with disabilities, and its impact in creating opportunity and support is felt in health care as elsewhere. An increasing number of physicians with disabilities who are practicing medicine today represent the "ADA generation," individuals who, prior to the legal protections afforded by the ADA, would have been deterred from pursuing a career in medicine [8].

While accommodations that provide physicians with disabilities the opportunity to practice medicine help to ensure a more safe and equitable practice environment for physicians with disabilities, such accommodations also offer benefits more broadly to the patients they serve and by extension can strengthen the patient-physician relationship. Experts recognize that concordance between patients and physicians with disability is key in enhancing quality of care, noting that "increasing the number of physicians who actively identify as having a disability and who require accommodations to practice could improve health care experiences and outcomes for patients with disabilities", as they are better able to "provide patient-centered care" with greater empathy [9, 10]. Removing barriers to practice, when and where they are unnecessary, is ethically required and promotes a more just and diverse workforce [11]. Diversity is essential to combating bias and building empathy; as Ouellette succinctly notes: "one way to counter bias against outsiders [disabled patients] is to make them insiders [physicians]" [10].

Removing barriers should extend to those who seek to enter the profession as well. Technical standards—criteria for medical school admission that require applicants to "demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance" (emphasis added) [12], create a fundamental barrier for prospective medical students. Experts argue that medical schools should adjust their technical standards from an approach that focuses on students' limitations to a functional approach that focuses on "students' abilities with or without the use of accommodations or assistive technologies" [12] Making such an adjustment is a fundamental step to creating a more inclusive medical profession to the benefit of all. Though there is much work still to be done, the available data suggest that individuals with disability are increasingly successful in becoming educated and trained in medicine. More physicians with disability now enjoy successful careers in medicine [8,13]. Barriers to practice are often "attitudinal or cultural in nature," not barriers born from a valid foundation of safe medical practice [13].

RETURN TO SAFE PRACTICE

Physicians who have undergone successful treatment for an impairing condition or received an accommodation that enables the physician to practice safely should have the right and the

1 opportunity to practice medicine again. Data has demonstrated, that with proper treatment and help,
2 physicians can successfully recover and return to practice [7,14].
3

4 A 2013 report by the FSMB offered guidance for state boards and physician health programs
5 regarding re-entry to practice by impaired physicians [15]. Those recommendations provide for:
6

- 7 • Case by case review informed by FSMB's Policy on Physician Impairment,
- 8 • A re-entry plan modeled on the 2012 FSMB guide on re-entry that addressed matters of timing
9 of re-entry, barriers, and common terminology [16].
10

11 CONCLUSION

12

13 Physician impairment can be the result of any illness or condition - physical or mental. In the
14 interest of patient safety and to meet the profession's ethical obligation of self-regulation, it is
15 important for physicians to be self-aware and sensitive to pressures of training and practice
16 environments and be prepared to respond when signs of impairment are observed, both in
17 themselves and their colleagues. Impaired physicians should receive the intervention and treatment
18 needed and be given the opportunity to rehabilitate and reenter practice safely. Physicians should
19 also be mindful that not all disability and illness cause impairment.
20

21 Society, health care systems, educational and training institutions, and practice environments must
22 continue, where possible, to accommodate the needs of all physicians, including those with
23 identified illness and disability. Medical schools should be encouraged to have technical standards
24 that allow for students with non-impairing disabilities to enter the profession. Society and the
25 profession must also have effective mechanisms in place to recognize and respond to physician
26 impairment, in the interest of patient safety and meeting the needs to colleagues who can and want
27 to be rehabilitated and reenter practice. The goal should be that with appropriate care or
28 accommodations a physician will ultimately be able to return to practice safely and effectively, if
29 possible.
30

31 RECOMMENDATION

32

33 The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician
34 Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues
35 with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder
36 of this report be filed:
37

38 Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote
39 patient welfare. Yet a variety of physical and mental health conditions—including physical
40 disability, medical illness, and substance use—can undermine physicians' ability to fulfill that
41 obligation. These conditions in turn can put patients at risk, compromise physicians'
42 relationships with patients, as well as colleagues, and undermine public trust in the profession.
43

44 While some conditions may render it impossible for a physician to provide care safely, with
45 appropriate accommodations or treatment many can responsibly continue to practice, or resume
46 practice once those needs have been met. In carrying out their responsibilities to colleagues,
47 patients, and the public, physicians should strive to employ a process that distinguishes
48 conditions that are permanently incompatible with the safe practice of medicine from those that
49 are not and respond accordingly.

1 As individuals, physicians should:

- 2
- 3 (a) Maintain their own physical and mental health, strive for self-awareness, and promote
- 4 recognition of and resources to address conditions that may cause impairment.
- 5
- 6 (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping
- 7 with ethics guidance on physician health and competence.
- 8
- 9 (c) Intervene with respect and compassion when a colleague is not able to practice safely.
- 10 Such intervention should strive to ensure that the colleague is no longer endangering
- 11 patients and that the individual receive appropriate evaluation and care to treat any
- 12 impairing conditions.
- 13
- 14 (d) Protect the interests of patients by promoting appropriate interventions when a colleague
- 15 continues to provide unsafe care despite efforts to dissuade them from practice.
- 16
- 17 (e) Seek assistance when intervening, in keeping with institutional policies, regulatory
- 18 requirements, or applicable law.
- 19

20 Collectively, physicians should nurture a respectful, supportive professional culture by:

- 21
- 22 (f) Encouraging the development of practice environments that promote collegial mutual
- 23 support in the interest of patient safety.
- 24
- 25 (g) Encouraging development of inclusive training standards that enable individuals with
- 26 disabilities to enter the profession and have safe, successful careers.
- 27
- 28 (h) Eliminating stigma within the profession regarding illness and disability.
- 29
- 30 (i) Advocating for supportive services and accommodations to enable physicians who require
- 31 assistance to provide safe, effective care.
- 32
- 33 (j) Advocating for respectful and supportive, evidence-based peer review policies and
- 34 practices that will ensure patient safety and practice competency.
- 35

36 Modify HOD/CEJA policy

Fiscal Note: Less than \$500

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REPORT 4 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (June 2021)
Augmented Intelligence & the Ethics of Innovation in Medicine
(Informational)

EXECUTIVE SUMMARY

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals.

Ethically appropriate use of augmented intelligence in health care must support, not subvert, the goals and values that define medicine as a profession. Design and implementation of systems for clinical use must take account of:

- risks to privacy;
- the potential for bias to be built into models and their outputs;
- the fact that the most powerful and useful models have the capacity to evolve autonomously, outside of human observation and independent of human control; and
- the challenge of devising mechanisms to ensure appropriate oversight across multiple stakeholders.

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them—for example, Harvard University's Berkman Klein Center for Internet & Society and the High Level Expert Group on AI of the European Commission.

The introduction of AI systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in this report as well future reports.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-JUN-21

Subject: Augmented Intelligence & the Ethics of Innovation in Medicine

Presented by: Monique A. Spillman, MD, Chair

AUGMENTED INTELLIGENCE & THE ETHICS OF INNOVATION IN MEDICINE

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals [1,2,3,4].

The AMA Council on Ethical and Judicial Affairs (CEJA) recognizes that AI-based tools can serve a variety of ends in health care, from supporting administrative functions and streamlining institutional operations to enhancing clinical decision making for individual patients [see, e.g., 2,5]. AI systems have strengths and weaknesses across all these areas; in the council's view, the characteristics of systems that are intended to inform diagnosis, predict a patient's clinical course, and support clinical decision making, highlight the risks AI-enabled care can pose to patients and are therefore the primary focus of the present analysis.

CHALLENGES OF AI-ENABLED HEALTH CARE

Several features distinguish the data-driven machine-learning algorithms in clinical prediction models and decision support tools from other innovations in medicine that ethics guidance must take account of: the potential for bias to be built into a model and its outputs; the fact that the most powerful and useful models are both opaque and plastic, that is, they have the capacity to evolve autonomously, outside of human observation and independent of human control. It also requires recognizing that not only do these AI systems involve multiple stakeholders, but that they also "transform the modes of interaction between different agents" [6], creating challenges for devising mechanisms to govern complex AI systems and appropriately hold multiple stakeholders accountable for the performance of those systems.

A Word About Privacy

Protecting the privacy of data subjects and the confidentiality of personal information is frequently cited as a central concern in the use of AI systems [7]. However, such risks are hardly unique to AI. They are common to all activities that collect and store personal information, especially activities that rely on data stored in central repositories—electronic health records, clinical registries, DNA databanks, or tissue banks intended for research use [see, e.g. 8]. The potential for benefit is great but risks that identifiable personal information will be inadvertently disclosed or worse, intentionally misused, are high in all activities that rely on sharing access to data sets that contain such information. For these reasons, the present analysis focuses more narrowly on other features unique to characteristic especially of predictive models and decision support tools that utilize machine-learning algorithms.

Bias

Data-driven machine-learning algorithms are subject to the familiar problem of “garbage in, garbage out.” The utility and value of such algorithms is hostage to the quality of the data on which they are trained and with which they are validated. Data drawn from electronic health records (EHRs), on which most such algorithms are currently trained, build into the model itself whatever biases already characterize the data in the record, whether statistical or social [9].

As data sets, EHRs have serious weaknesses. Insofar as they include only information from individuals who have access to the health care system in the first place, and in settings that employ electronic records, they are not representative. Information about individuals who have no or irregular access to care, or whose records exist only in paper form is not available to train or validate an algorithm. Nor are EHR data “pristine”—with rare exceptions, electronic records capture information “downstream” of human judgments, in effect training the algorithm to replicate human cognitive errors as well as any design flaws in the record system itself [9,10].

Even well-intended efforts to correct for possible bias can have unintended consequences. For example, race-adjusted assessments for clinical conditions are often based on the misconception that “race” is a reliable proxy for genetic difference and fail to recognize that “race and health reflect enmeshed social and biologic pathways” [11]. Rather than correct for inequity, these algorithms may direct resources away from patients who are members of minoritized populations and inappropriately propagate race-based medicine instead of the equitable personalized care intended [11]. Moreover, algorithms that are fair out of the box can become biased over time once implemented, affected by characteristics of the contexts, goals, and ways they are deployed [12].

Technical solutions are being explored to mitigate bias before, during, or after an algorithm processes data [9,13].

Opacity & Plasticity

The operation of a machine-learning algorithm can be opaque for any of several reasons. In some cases, this is intentional, such as interest in protecting proprietary information; in others it reflects the fact that being able to read and interpret computer code remains a specialized skill not yet widely shared. A more fundamental challenge, however, lies in understanding highly complex algorithms as they operate on data [14]. The most powerful—and useful—algorithms are “black boxes.” As a machine-learning algorithm operates on data its internal decision logic “is altered as the algorithm ‘learns’” [14]. Such algorithms have the capacity to evolve in ways that may be impenetrable to human understanding – even to their developers. Because the algorithm’s operations “do not naturally accord with human semantic explanations,” attempts to provide humanly understandable explanations are “at best incomplete and at worst falsely reassuring” [14]. In this, data-driven AI systems are qualitatively different from other innovations in medicine.

Validation

Robust validation lags the development of AI systems in health care. For example, of some 1366 cardiovascular clinical prediction models (CPM) in the Tufts PACE Clinical Prediction Model registry, fewer than 600 reported at least one validation [15]. Current practice generally assesses only a single model at a time and thus cannot provide “reliable ranking of the comparative performance of the many CPMs available for the same application,” which allows a small number of models to dominate clinical practice “based on tradition and herding behavior, rather than high-quality evidence” [15]. Randomized clinical trials that assess the clinical utility of CPMs are rare.

Physicians need to be critical consumers of published reports about new AI models, and take into account not only where a report was published, but the source and size of the dataset on which the algorithm was based, whether it was tested on real clinical data, whether its performance was compared to existing solutions, whether it was evaluated for how readily it can be implemented, and whether its results were interpretable to the intended end users [5].

In response to the “current lack of best practice guidance specific to machine learning and artificial intelligence,” researchers have proposed 20 key questions to address issues of transparency, reproducibility, ethics, and effectiveness in research involving machine learning and AI [16]. These questions probe issues of inception (e.g., “What is the health question relating to patient benefit”), study design (“Are the data suitable to answer the clinical question...?”), statistical methods, reproducibility, impact (e.g., “Are the results generalizable to settings beyond where the system was developed...?”), and implementation (e.g., “How is the model being regularly reassessed and updated as data quality and clinical practice changes...?”).

Oversight & Accountability

Debate continues about whether or to what extent existing models for oversight of medical technologies can be adapted to provide adequate oversight of AI systems in health care. Models for human subjects protections are poorly suited to the evolving “cyber social experiment” [17] represented by machine-learning algorithms, for essentially the same reasons these protections are problematic in contexts of quality improvement activities, or other research that involves the use of personal health or genetic data or stored biological materials [8]. Nor do machine-learning algorithms fit comfortably within current paradigms for oversight of medical devices, even the Food and Drug Administration’s new regulatory framework created under the 21st Century Cures Act [8,18].

Beyond regulatory oversight, the increasing complexity and power of AI systems have prompted calls for the health care organizations that deploy such systems to implement programs of “algorithmic stewardship,” analogous to antimicrobial stewardship, “to ensure that algorithms are used safely, effectively, and fairly” [19]. On this model, a designated body within the institution would be tasked with creating and maintaining an inventory of the algorithms deployed within the institution and monitoring the performance of AI systems.

Importantly, inserting AI systems into the process of clinical decision making distributes agency among multiple entities—the patient, the physician, the AI system, its designers, the data set on which it was trained, the institution that deployed it—raising questions about “who is guiding clinical decision-making, in which ways, and on what grounds” [6]. This in turn

“raises a problem of many hands for ascriptions of responsibility: since a plurality of agents contributes to decision-making guided by AI-DSS [decision support systems], it becomes less clear who is morally and legally answerable in which ways. With the involvement of autonomous, adaptive and learning systems, it becomes harder to ascribe individual responsibility and liability for singular decisions, especially those with adverse outcomes” [6].

FRAMEWORKS FOR ETHICAL AI

That these challenges are well recognized is evidenced by multiple published frameworks for an “ethics of AI,” and, importantly, the convergence on key principles among them. Thus, a review prepared by Harvard University’s Berkman Klein Center for Internet & Society identified the following as common themes among 36 discussions of “how AI generally *ought* to be developed,

1 deployed, and governed” from governmental agencies, corporations, and private sector
2 organizations [7]:

- 3
- 4 • Privacy—data subjects have some degree of influence over how and why information
- 5 about them is used
- 6 • Accountability—AI systems should be subject to appropriate oversight during
- 7 development and deployment, and that appropriate remedies be provided if harm occurs
- 8 • Safety and security—AI systems should be reliable and perform as intended, and that
- 9 systems are appropriately protected against external threats
- 10 • Transparency and explainability—it is clear when AI systems are being used and for what
- 11 task, and that justifications for decision outputs be intelligible
- 12 • Fairness and nondiscrimination—steps are taken to prevent and mitigate against
- 13 discrimination risks in the design, development and application of AI systems
- 14 • Human control of technology—important decisions remain subject to human control
- 15 • Professional responsibility—individuals and teams involved in the design, development
- 16 and deployment of AI systems take responsibility for the performance and effects of those
- 17 systems
- 18 • Promotion of human values—the ends to which AI systems are devoted and the means by
- 19 which they are implemented should correspond with core social norms
- 20

21 The High Level Expert Group on AI of the European Commission identifies five fundamental
22 ethical principles to govern the design and deployment of AI systems [20]:

- 23
- 24 • Beneficence (“do good”)—AI systems should be designed and developed to improve
- 25 individual and collective well-being.
- 26 • Non-maleficence (“do no harm”)—By design, AI systems should protect the dignity,
- 27 integrity, liberty, privacy, safety, and security of human beings At the very least, AI
- 28 systems should not be designed in a way that enhances existing harms or creates new
- 29 harms for individuals.
- 30 • Autonomy (“preserve human agency”)—Autonomy of human beings in the context of AI
- 31 means freedom from subordination to, or coercion by, AI systems. Human beings
- 32 interacting with AI systems must keep full and effective self-determination over
- 33 themselves.
- 34 • Justice (“be fair”)—The principle of justice imparts that the development, use, and
- 35 regulation of AI systems must be fair. Developers and implementers need to ensure that
- 36 individuals and minoritized groups maintain freedom from bias, stigmatization, and
- 37 discrimination.
- 38 • Explicability (“operate transparently”)—Technological transparency implies that AI
- 39 systems be auditable, comprehensible and intelligible by human beings at varying levels of
- 40 comprehension and expertise. Business model transparency means that human beings are
- 41 knowingly informed of the intention of developers and technology implementers of AI
- 42 systems.
- 43

44 A report by the Digital Health Learning Collaborative of the National Academy of Medicine
45 similarly identifies beneficence, non-maleficence, autonomy, and justice as fundamental principles
46 for ethical AI in medicine [4].

MOVING FROM PRINCIPLES TO PRACTICE

Recognizing the distinctive challenges AI systems can pose and agreeing on key values and principles that should inform AI systems is essential, but is not enough to guarantee the design, development, and deployment of “ethical AI” in health care or any other domain. As a report by the Gradient Institute has observed, AI systems “possess no intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions” [21].

Algorithms consider only the objectives and constraints supplied by their designers. To embed fundamental ethical considerations into AI systems requires that governing ethical objectives and constraints—for example, “fairness”—be expressed mathematically, as “precise, measurable quantities.” For an algorithm to approximate the ethical reasoning a human would bring to bear in making a given decision, its designers must also specify acceptable balances among competing objectives [21]. Further, as some researchers have noted, “analyses of algorithmic fairness in healthcare lack the contextual grounding and causal awareness necessary to reason about the mechanisms that lead to health disparities, as well as about the potential of algorithmic fairness methods to counteract those mechanisms” [22].

Moreover, AI systems must be designed so that the consequences of a system’s actions “align with the ethical intent motivating the deployment of the system” [21]. That is, systems must not only be designed in ways that account for bias in training data, but in ways that enable them to apply causal reasoning to model the consequences of its actions and assess the relative likelihood of those consequences occurring. Mathematically representing the kind of multidisciplinary expertise and sensitivity to context that characterize human moral is extremely difficult.

Given these realities, human oversight of AI systems is essential. If overseers are to be able to “anticipate, detect, and correct problems,” an AI system must be transparent and interpretable. To reduce the risk that an AI system “will be motivated, designed, or operated in a socially unacceptable way,” decisions first must be made about what information needs to be made transparent to whom. The system must further be interpretable in ways that enable people “to understand [a system’s] reasoning processes, explain how mistakes occurred, or inform users how to adapt their behavior to obtain different decisions from systems in the future” [21]. Yet, like “fairness,” interpretability, often comes at the cost of accuracy, and “determining what attainable compromise between predictive power and effective human oversight results in the best ethical outcomes” will remain a challenge for the foreseeable future.

Finally, Gradient’s analysis proposes, oversight and accountability for ethical AI should be sensitive to the complex nature of AI systems and to the multiple contexts in which those systems are used, noting that “labelling requirements, special taxation or regulatory approval processes for ‘AI systems’ broadly construed” are “unlikely to be helpful” [21]. They propose, instead, sector-specific oversight of the contexts in which AI systems are applied, to permit evidence-based, technically informed regulation that is able to keep pace with rapid, ongoing evolution in the technology.

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

The *AMA Code of Medical Ethics* defines fidelity to patients and physicians’ corresponding responsibility to promote patients’ well-being as the core value of medicine as a profession. Opinion [1.1.1](#), “Patient-Physician Relationships,” holds that

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

Innovations in health care should sustain this fundamental commitment of fidelity to patients. Those who design and deploy new interventions or technologies, particularly interventions or technologies intended to directly interface with decisions about patient care, have a responsibility to ensure that their work serves the goals of medicine as a priority. Thus Opinion [1.2.11](#), "Ethically sound innovation in medical practice," provides that any given innovation must be scientifically well grounded and focus on the interests of patients, not those of innovators or health care institutions.

Guidance in Opinion 1.2.11 further recognizes that introducing new technologies or other innovation into medical practice poses challenges at the systemic level as well as for individual physicians. Strong practice requires attention not only to individual clinical interactions "at the bedside," but equally to the organizational policies, practices, and infrastructure of health care institutions that deploy a medical innovation. Innovators have a responsibility to engage stakeholders early in the process and must consciously design innovations to minimize risks to individual patients and maximize the likelihood they will be adopted and will benefit populations of patients. Innovators also have an ethical obligation to be sensitive to the cost implications of innovation and aware of influences that may drive the creation and adoption of innovations for reasons other than patient or public benefit. Institutions and physician practices that adopt innovations have a responsibility to ensure that appropriate infrastructure is in place to support effective implementation and oversight.

Guidance in Opinion [11.2.1](#), "Professionalism in Health Care Systems," sets out the responsibilities of physician-leaders to create conditions that support physician professionalism within their organizations, including responsibilities to ensure that institutional arrangements that govern care are transparent and that decisions reflect input from key stakeholders. It defines leaders' responsibilities to ensure that mechanisms adopted to influence physician decision making are "designed in keeping with sound principles and solid scientific evidence," deployed fairly so that they "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities." It further holds physician-leaders responsible to ensure the institution provides avenues "for meaningful appeal and advocacy on behalf of patients" and for monitoring deployment of new practices and tools to identify and respond to their effects on patient care.

ASKING THE RIGHT QUESTIONS

The majority of physicians will be consumers of AI systems developed by others—including even those physicians who are affiliated with institutions that are actively engaged in developing AI for health care. As individual end users, physicians cannot reasonably be expected to have the requisite skills or opportunity to evaluate AI systems, and should not be, any more than they are expected to make firsthand assessment of other diagnostic or therapeutic innovations. They must rely on their institutions—or the vendors from whom they purchase AI systems for their practices—to ensure that those systems are trustworthy.

Ethically appropriate use of AI in health care must support, not subvert, the goals and values that define medicine as a profession. Physicians should be thoughtful consumers of AI and recognize

1 that they have a responsibility to use their voice as professionals and their knowledge of their
2 patients' needs to help inform decisions about what AI systems will be implemented in the care
3 settings in which they practice. They should be able to expect that health care institutions with
4 which they are affiliated can answer the following questions when deploying an AI system that will
5 affect clinical practice:

- 6
- 7 • What recognized clinical need among our patient population is this tool intended to
- 8 address?
- 9 • Has it been rigorously demonstrated to successfully meet that need among patients
- 10 relevantly similar to ours in comparable clinical settings?
- 11 ○ By whom?
- 12 • What is the worst that could happen to the person who is most adversely affected if we
- 13 deploy this system?
- 14 ○ Are those who are most likely to be adversely affected already disadvantaged
- 15 compared to others?
- 16 ○ How will the institution minimize the possibility of a “worst case” scenario
- 17 occurring?
- 18 • Through what process and by whom was the decision made to acquire and deploy this
- 19 technology at this time?
- 20 • What resources, in both personnel and infrastructure, are needed to deploy this technology
- 21 successfully?
- 22 ○ How will the institution ensure that these resources are available?
- 23 • How will the institution monitor the performance of this system once it is deployed?
- 24 ○ Are there clear protocols for clinicians to contribute to performance assessment?
- 25 To regularly receive information about the system's impact on patient
- 26 care/outcomes?
- 27 • How will the institution support my exercise of professional clinical judgment and
- 28 expertise with respect to clinical predictions or treatment recommendations generated by
- 29 this AI system?
- 30

31 CONCLUSION

32

33 As the foregoing analysis indicates, the introduction of augmented intelligence systems in medicine
34 touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical
35 Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to
36 conclude that new guidance directed solely toward AI will not best serve the profession. Therefore,
37 the Council proposes to review existing guidance in the areas of relevance to AI and to share its
38 deliberations with the House of Delegates in future reports.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-JUN-21

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Monique A. Spillman, MD, Chair

- 1 At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a
2 detailed explanation of its judicial function. This undertaking was motivated in part by the
3 considerable attention professionalism has received in many areas of medicine, including the
4 concept of professional self-regulation.
5
- 6 CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove
7 a membership application or to take action against a member. The disciplinary process begins when
8 a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an
9 applicant or member is reported to the AMA. This information most often comes from statements
10 made in the membership application form, a report of disciplinary action taken by state licensing
11 authorities or other membership organizations, or a report of action taken by a government tribunal.
12
- 13 The Council rarely re-examines determinations of liability or sanctions imposed by other entities.
14 However, it also does not impose its own sanctions without first offering a hearing to the physician.
15 CEJA can impose the following sanctions: applicants can be accepted into membership without any
16 condition, placed under monitoring, or placed on probation. They also may be accepted, but be the
17 object of an admonishment, a reprimand, or censure. In some cases, their application can be
18 rejected. Existing members similarly may be placed under monitoring or on probation, and can be
19 admonished, reprimanded or censured. Additionally, their membership may be suspended or they
20 may be expelled. Updated rules for review of membership can be found at [https://www.ama-](https://www.ama-assn.org/governing-rules)
21 [assn.org/governing-rules](https://www.ama-assn.org/governing-rules).
22
- 23 Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial
24 activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities
25 during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2020 – MARCH 31, 2021

Physicians Reviewed	<u>SUMMARY OF CEJA ACTIVITIES</u>
10	Determinations of no probable cause
22	Determinations following a plenary hearing
7	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	<u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u>
10	No sanction or other type of action
5	Monitoring
6	Probation
1	Revocation
7	Suspension
1	Denied
1	Suspension lifted
3	Censure
2	Reprimand
3	Admonish

Physicians Reviewed	<u>PROBATION/MONITORING STATUS</u>
6	Members placed on Probation/Monitoring during reporting interval
6	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation
48	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
18	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-JUN-21

Subject: Amendment to Opinion 1.2.2, “Disruptive Behavior and Discrimination by Patients”

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1, November 2020, “Amendment to Opinion 1.2.2, ‘Disruptive Behavior and Discrimination by Patients.’” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.2 – Disruptive Behavior and Discrimination by Patients’

The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting the dignity and rights of both patients and physicians.

Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

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

- (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those who are targeted.
- (b) Always treat patients with compassion and respect.
- (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

1 patient behavior. Regardless of cause, when a patient's behavior threatens the safety of
2 health care personnel or other patients, steps should be taken to de-escalate or remove
3 the threat.

- 4
- 5 (d) Prioritize the goals of care when deciding whether to decline or accommodate a
6 patient's request for an alternative physician. Physicians should recognize that some
7 requests for a concordant physician may be clinically useful or promote improved
8 outcomes.
- 9
- 10 (e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable
11 learning opportunities solely to accommodate prejudiced requests.
- 12
- 13 (f) Make patients aware that they are able to seek care from other sources if they persist in
14 opposing treatment from the physician assigned. If patients require immediate care,
15 inform them that, unless they exercise their right to leave, care will be provided by
16 appropriately qualified staff independent of their expressed preference.
- 17
- 18 (g) Terminate the patient-physician relationship only when the patient will not modify
19 disrespectful, derogatory or prejudiced behavior that is within the patient's control, in
20 keeping with ethics guidance.
- 21

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

24

- 25 (h) Be mindful of the messages the institution conveys within and outside its walls by how
26 it responds to prejudiced behavior by patients.
- 27
- 28 (i) Educate staff, patients, and the community about the institution's expectations for
29 behavior.
- 30
- 31 (j) Promote a safe and respectful working environment and formally set clear expectations
32 for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.
- 33
- 34 (k) Clearly and openly support physicians, trainees, and facility personnel who experience
35 prejudiced behavior and discrimination by patients, including allowing physicians,
36 trainees, and facility personnel to decline to care for those patients, without penalty,
37 who have exhibited discriminatory behavior specifically toward them.
- 38
- 39 (l) Collect data regarding incidents of discrimination by patients and their effects on
40 physicians and facility personnel on an ongoing basis and seek to improve how
41 incidents are addressed to better meet the needs of patients, physicians, other facility
42 personnel, and the community. (I, II, VI, IX)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-JUN-21

Subject: Amendment to Opinion 8.7, “Routine Universal Immunization of Physicians”

Presented by: Monique A. Spillman, MD, Chair

1 INTRODUCTION

2
3 At the November 2020 Special Meeting, the American Medical Association House of Delegates
4 adopted the recommendations of Council on Ethical and Judicial Affairs Report 2, November 2020,
5 “Amendment to Opinion 8.7, ‘Routine Universal Immunization of Physicians.’” The Council
6 issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print
7 edition of the *Code of Medical Ethics*.
8

9 E-8.7 – Routine Universal Immunization of Physicians

10
11 As professionals committed to promoting the welfare of individual patients and the health of
12 the public and to safeguarding their own and their colleagues’ well-being, physicians have an
13 ethical responsibility to encourage patients to accept immunization when the patient can do so
14 safely, and to take appropriate measures in their own practice to prevent the spread of
15 infectious disease in health care settings. Conscientious participation in routine infection
16 control practices, such as hand washing and respiratory precautions is a basic expectation of
17 the profession. In some situations, however, routine infection control is not sufficient to protect
18 the interests of patients, the public, and fellow health care workers.
19

20 In the context of a highly transmissible disease that poses significant medical risk for
21 vulnerable patients or colleagues, or threatens the availability of the health care workforce,
22 particularly a disease that has potential to become epidemic or pandemic, and for which there is
23 an available, safe, and effective vaccine, physicians have a responsibility to accept
24 immunization absent a recognized medical contraindication or when a specific vaccine would
25 pose a significant risk to the physician’s patients.
26

27 Physicians who are not or cannot be immunized have a responsibility to voluntarily take
28 appropriate action to protect patients, fellow health care workers and others. They must adjust
29 their practice activities in keeping with decisions of the medical staff, institutional policy, or
30 public health policy, including refraining from direct patient contact when appropriate.
31

32 Physician practices and health care institutions have a responsibility to proactively develop
33 policies and procedures for responding to epidemic or pandemic disease with input from

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1 practicing physicians, institutional leadership, and appropriate specialists. Such policies and
2 procedures should include robust infection control practices, provision and required use of
3 appropriate protective equipment, and a process for making appropriate immunization readily
4 available to staff. During outbreaks of vaccine-preventable disease for which there is a safe,
5 effective vaccine, institutions' responsibility may extend to requiring immunization of staff.
6 Physician practices and health care institutions have a further responsibility to limit patient and
7 staff exposure to individuals who are not immunized, which may include requiring
8 unimmunized individuals to refrain from direct patient contact. (I, II)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-JUN-21

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Shannon P. Pryor, MD, Chair

1 This informational report is prepared in odd numbered years by the Council on Long Range
2 Planning and Development (CLRPD, pursuant to AMA Policy G-600.035, “The Demographics of
3 the House of Delegates.” This policy states:

4
5 (1) A report on the demographics of our AMA House of Delegates will be issued annually and
6 include information regarding age, gender, race/ethnicity, education, life stage, present
7 employment, and self-designated specialty. (2) As one means of encouraging greater awareness
8 and responsiveness to diversity, our AMA will prepare and distribute a state-by-state
9 demographic analysis of the House of Delegates, with comparisons to the physician population
10 and to our AMA physician membership every other year. (3) Future reports on the
11 demographic characteristics of the House of Delegates should, whenever possible, identify and
12 include information on successful initiatives and best practices to promote diversity within
13 state and specialty society delegations.

14
15 This report will survey the current demographic makeup of AMA leadership in accordance with
16 AMA Policy G-600.030, “Diversity of AMA Delegations,” which states that, “Our AMA
17 encourages...state medical associations and national medical specialty societies to review the
18 composition of their AMA delegations with regard to enhancing diversity...” and AMA Policy
19 G-610.010, “Nominations,” which states in part:

20
21 Guidelines for nominations for AMA elected offices include the following... (2) the Federation
22 (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in
23 electing Council and Board members), and the Board, the Speakers, and the President (in
24 appointing or nominating physicians for service on AMA Councils or in other leadership
25 positions) to consider the need to enhance and promote diversity...

26
27 Like previous reports, this document compares AMA leadership with the entire AMA membership
28 and with the overall U.S. physician population. Medical students are included in all references to
29 the total physician population, which is consistent with past practice. For the purposes of this
30 report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and
31 councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed
32 listing in Appendix A).

33
34 Additionally, this report includes information on successful initiatives and best practices to
35 promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2020 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2020 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2020 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for slightly over one-fifth of AMA members (21.8%) and the total U.S. physician population (22.7%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership"; the following observations refer to changes since CLRPD Report 1-A-19. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2018 and year-end 2020, AMA membership increased by 21,402 members, an 8.6% increase.

- Younger age groups saw increases in representation among the delegates to the HOD, with the percentage of delegates under age 40 increasing from 14.1% in 2018 to 16.2% in 2020, and delegates age 40-49 increasing from 10.4% to 13.3%. Concurrent with these increases, the percentage of delegates age 50-59 decreased from 22.2% in 2018 to 18.8% in 2020, while the percentage of delegates age 60-69 decreased from 34.5% to 32.2%.
- An increase was also observed among alternate delegates under age 40, from 22.7% in 2018 to 28.5% in 2020. The percentage of alternate delegates age 60-69 decreased from 26.2% to 22.7% during the same period.
- An increase was observed among female delegates, alternate delegates, and AMA members. The percentage of female members of the AMA increased from 35.7% to 38.0% from 2018 to 2020. During the same period, the percentage of female delegates to the HOD

- 1 increased from 26.4% to 30.7%, and the percentage of female alternate delegates increased
 2 from 33.2% to 38.3%.
- 3 • Increased percentages were observed among Asian/Asian American delegates, alternate
 4 delegates and CSSG from 2018 to 2020. During that time, the percentage of Asian/Asian
 5 American delegates increased from 9.1% to 11.5%, alternate delegates increased from
 6 13.5% to 15.9%, and CSSG increased from 15.3% to 19.9%. Simultaneous decreases were
 7 observed among white, non-Hispanic alternate delegates (from 66.6% to 63.4%) and CSSG
 8 (from 59.4% to 55.4%).

Table 1. Basic Demographic Characteristics of AMA Leadership, December 2020

	Delegates ²	Alternate Delegates ²	Board of Trustees ³	Councils and Leadership of Sections and Special Groups ⁴	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years) ⁵	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	16.2%↑	28.5%↑	10.0%	27.7%↓	51.3%	29.3%
40-49 years	13.3%↑	18.1%	15.0%	16.3%↑	10.8%	18.0%
50-59 years	18.8%↓	22.4%	30.0%	15.7%	9.9%	16.9%
60-69 years	32.2%↓	22.7%↓	40.0%	25.9%	10.3%	16.8%
70 or more	19.5%	8.3%	5.0%	14.5%	17.7%	19.0%
Gender						
Male	69.2%↓	61.7%↓	65.0%	52.4%	61.4%↓	63.8%
Female	30.7%↑	38.3%↑	35.0%	47.6%	38.0%↑	35.5%
Unknown	0.1%	0.0%	0.0%	0.0%	0.6%	0.7%
Race/Ethnicity						
White non-Hispanic	68.3%	63.4%↓	60.0%	55.4%↓	49.9%↓	50.1%
Black non-Hispanic	4.6%	5.0%	15.0%	7.2%	5.0%	4.3%
Hispanic	3.1%	3.1%	0.0%	4.8%	6.0%	5.7%
Asian/Asian American	11.5%↑	15.9%↑	10.0%	19.9%↑	15.5%	15.4%
Native American	0.1%	0.2%	0.0%	0.0%	0.4%	0.3%
Other ⁶	1.3%	2.2%	0.0%	1.2%	1.4%	1.4%
Unknown	11.0%	10.2%	15.0%	11.4%	21.8%	22.7%
Education						
US or Canada	92.0%	92.2%	100.0%	86.7%↑	82.4%	77.6%
IMG	8.0%	7.8%	0.0%	13.3%	17.6%	22.4%

²Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

³Numbers do not include the public member of the Board of Trustees, who is not a physician.

⁴Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.

⁵Age as of December 31. Mean age is the arithmetic average.

⁶Includes other self-reported racial and ethnic groups.

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- The life stage, employment, and specialty characteristics of delegates to the HOD saw few changes from 2018 to 2020, with decreases observed among established physicians (from 49.8% in 2018 to 45.8% in 2020) and self-employed solo practice physicians (from 15.0% to 13.0%).
- Among alternate delegates, increased proportional representation was observed among students (6.2% to 9.4%) and residents (5.7% to 8.5%), while decreases were observed among established physicians (52.4% to 49.7%) and senior physicians (21.9% to 19.4%). The percentage of alternate delegates employed in group practice settings (39.9% to 37.7%), state or local government hospitals (11.5% to 8.7%) and medical schools (11.5% to 8.7%) declined, as did physicians whose self-designated specialty was surgery (20.4% to 17.9%) and other (17.7% to 15.0%).
- Among CSSG, the percentages of students (11.8% to 8.4%) and young physicians (15.9% to 9.6%) decreased, while the percentage of established physicians increased from 34.1% to 41.0%. Decreases in representation were also observed among physicians working in self-employed solo practice (12.4% to 10.2%) and medical schools (8.8% to 5.4%), while representation of physicians in group practices increased from 27.6% to 33.7%. Among specialties, increases were observed in family medicine (6.5% to 9.6%), internal medicine (14.7% to 18.7%), and obstetrics and gynecology (9.4% to 13.3%), and decreases were observed in surgery (19.4% to 16.9%) and psychiatry (8.2% to 6.0%).

Table 2. Life Stage, Present Employment and Self-Designated Specialty¹ of AMA Leadership, December 2020

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student ²	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Resident ²	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Young (Under age 40 or first eight years of practice) [^]	7.0%	13.1%	0.0%	9.6%↓	9.6%	15.7%
Established (Age 40-64) [^]	45.8%↓	49.7%↓	60.0%	41.0%↑	22.1%	39.3%
Senior (Age 65 or more) [^]	36.4%	19.4%↓	30.0%	28.9%	22.8%	27.2%
Present Employment						
Self-employed solo practice	13.0%↓	9.6%	20.0%	10.2%↓	6.7%	8.3%
Two physician practice	1.5%	2.0%	10.0%	1.8%	1.4%	1.8%
Group practice	41.7%	37.7%↓	40.0%	33.7%↑	24.0%	40.2%
Non-government hospital	6.1%	6.5%	5.0%	4.2%	3.1%	4.3%
State or local government hospital	10.3%	8.7%↓	5.0%	10.8%	3.9%	6.3%
HMO	0.7%	1.3%	0.0%	0.6%	0.2%	0.2%

[^] Reflects section/group definition of its membership.

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Medical School	3.7%	2.8%↓	10.0%	5.4%↓	1.0%	1.5%
U.S. Government	3.3%	4.1%	0.0%	2.4%	0.9%	1.7%
Locum Tenens	0.4%	0.0%	0.0%	0.0%	0.2%	0.2%
Retired/Inactive	6.9%	5.7%	0.0%	8.4%	11.1%	12.1%
Resident/Intern/Fellow	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Student	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Other/Unknown	1.5%	3.7%	0.0%	1.8%	1.9%	5.7%
Self-designated specialty³						
Family Medicine	10.6%	10.0%	5.0%	9.6%↑	8.5%	11.4%
Internal Medicine	22.7%	19.2%	30.0%	18.7%↑	19.7%	22.7%
Surgery	22.1%	17.9%↓	40.0%	16.9%↓	13.4%	13.4%
Pediatrics	3.3%	5.2%	0.0%	5.4%	5.2%	8.7%
OB/GYN	6.6%	6.1%	5.0%	13.3%↑	5.0%	4.6%
Radiology	5.4%	5.7%	0.0%	4.2%	3.5%	4.5%
Psychiatry	4.2%	4.4%	5.0%	6.0%↓	4.2%	5.2%
Anesthesiology	3.4%	3.9%	5.0%	3.6%	3.9%	5.0%
Pathology	1.9%	3.3%	0.0%	0.0%	1.8%	2.2%
Other specialty	15.2%	15.0%↓	5.0%	13.9%	13.9%	14.4%
Student	4.8%	9.4%	5.0%	8.4%↓	21.0%	8.0%

² Students and residents are so categorized without regard to age.

³ See Appendix B for a listing of specialty classifications.

For further data, including information on state medical associations and national medical specialty societies, please see Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity among their delegations, and the outcomes of these initiatives.

- Nominating committees: As has been noted in previous editions of this report, nominating committees act as a primary mechanism with which delegations attempt to promote diversity among their leadership and AMA representatives. Associations noted that their nominating committees are encouraged to consider the demographic makeup of their members, as well as those of leadership, including boards of trustees, delegations, etc. In addition to demographic characteristics previously listed, other elements of diversity considered by nominating committees included specialty, practice setting and geographic region.
- Task forces and committees on diversity, equity, and inclusion: An increasing number of associations have formed task forces and/or committees with the goals of increasing and promoting diversity, equity, and inclusion among their ranks. Among the goals of such groups are to develop strategies to encourage cultures of diversity, equity and inclusion across membership, leadership and educational activities; identify specific and actionable steps to advocate for and foster diverse and inclusive environments within their

associations and representatives to other organizations such as the AMA; review diversity and inclusion among their boards of trustees, committee chairs, committee members, annual meeting program participants, presenters and award recipients; and develop initiatives to ensure open access to leadership positions and other opportunities throughout their organizations. Associations that have implemented task forces and committees have noted that they have implemented many or all of the groups' recommendations, and that the efforts have led to increased diversity among their leaderships.

- Improved data collection: Several associations noted the need for baseline data to measure the effectiveness of diversity and inclusion initiatives and undertook efforts to collect necessary data. Such efforts included evaluating and updating questions in membership surveys, automated diversity data collection from volunteers for workgroups and representative positions, and the development of dashboards and other reporting mechanisms that help understand the demographic makeup of the various groups and representative positions within their associations. Lack of adequate demographic data, as well as hesitance to request data that some individuals may be uncomfortable providing, was routinely cited as a barrier to implementing and measuring the efficacy of diversity, equity, and inclusion initiatives.
- Educational and outreach efforts: Associations mentioned a variety of events and initiatives aimed to educate their members and the public on diversity and inclusion, as well as outreach efforts to demonstrate the value of associations to more diverse populations. Among those efforts were town halls on race, equality, and justice; social media campaigns featuring issues related to physician diversity, underserved communities, and disparities; expanding educational opportunities for students from underrepresented social groups at the undergraduate and graduate levels; implementation of a "diversity day" as part of annual awareness events (e.g., National Physicians Week); and collaborating with professional associations with similar foci to increase awareness of their efforts to underrepresented social groups. These efforts demonstrate that attempts to increase diversity among leadership within associations can also include efforts to recruit members from more diverse social groups to participate as members, which in turn lead to more diverse and representative leaders.
- Efforts to advance younger members: Delegations have made efforts to encourage more participation by previously underrepresented groups, particularly by engaging residents, medical students, and young physicians as active participants in delegation activities, including as delegates. The groups expressed hope that these younger members would continue participation in the future and participate as members of specialty and state delegations. These associations noted that in addition to increasing age diversity among leadership, younger members tend to be more diverse in terms of other demographic characteristics.

CLRPD hopes that these initiatives may act as useful examples for those societies considering strategies by which to promote diversity among their own memberships and leaders.

For raw counts of the above tables, as well as detailed state and specialty society data, please see the appendices.

APPENDIX A

Table 3. Basic Demographic Characteristics of AMA Leadership

	Delegates ²	Alternate Delegates ²	Board of Trustees ³	Councils and Leadership of Sections and Special Groups ⁴	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years) ⁵	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	109	131	2	46	139,355	407,345
40-49 years	89	83	3	27	29,271	250,268
50-59 years	126	103	6	26	26,992	235,857
60-69 years	216	104	8	43	28,081	233,980
70 or more	131	38	1	24	47,956	264,140
Gender						
Male	464	283	13	87	166,793	887,425
Female	206	176	7	79	103,274	494,657
Unknown	1	0	0	0	1,588	9,508
Race/Ethnicity						
White non-Hispanic	458	291	12	92	135,523	697,801
Black non-Hispanic	31	23	3	12	13,562	59,965
Hispanic	21	14	0	8	16,394	78,855
Asian/Asian American	77	73	2	33	42,101	214,602
Native American	1	1	0	0	974	3,764
Other ⁶	9	10	0	2	3,804	20,031
Unknown	74	47	3	19	59,297	316,572
Education						
US or Canada	617	423	20	144	223,820	1,079,301
IMG	54	36	0	22	47,835	312,289

² Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.³ Numbers do not include the public member of the Board of Trustees, who is not a physician.⁴ Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.⁵ Age as of December 31. Mean age is the arithmetic average.⁶ Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student ²	32	43	1	14	56,959	110,305
Resident ²	41	39	1	20	66,648	137,332
Young (Under age 40 or first eight years of practice) [^]	47	60	0	16	26,156	217,953
Established (Age 40-64) [^]	307	228	12	68	60,070	547,156
Senior (Age 65 or more) [^]	244	89	6	48	61,822	378,844
Present Employment						
Self-employed solo practice	87	44	4	17	18,275	114,866
Two physician practice	10	9	2	3	3,822	24,890
Group practice	280	173	8	56	65,113	558,755
Non-government hospital	41	30	1	7	8,478	59,952
State or local government hospital	69	40	1	18	10,605	87,872
HMO	5	6	0	1	613	2,301
Medical School	25	13	2	9	2,743	20,951
U.S. Government	22	19	0	4	2,508	24,069
Locum Tenens	3	0	0	0	430	2,786
Retired/Inactive	46	26	0	14	30,228	168,331
Resident/Intern/Fellow	41	39	1	20	66,648	137,332
Student	32	43	1	14	56,959	110,305
Other/Unknown	10	17	0	3	5,233	79,180
Self-designated specialty³						
Family Medicine	71	46	1	16	23,140	158,727
Internal Medicine	152	88	6	31	53,524	316,032
Surgery	148	82	8	28	36,344	186,535
Pediatrics	22	24	0	9	14,203	120,915
OB/GYN	44	28	1	22	13,636	64,059
Radiology	36	26	0	7	9,558	62,156
Psychiatry	28	20	1	10	11,301	72,180
Anesthesiology	23	18	1	6	10,521	69,030
Pathology	13	15	0	0	4,754	30,997
Other specialty	102	69	1	23	37,676	200,103
Student	32	43	1	14	56,998	110,856

² Students and residents are so categorized without regard to age.³ See Appendix B for a listing of specialty classifications.[^] Reflects section/group definition of its membership.

Table 5. Characteristics of Specialty Society Delegations¹

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =271,655)	47.0	38.0%	17.6%	24.5%
Specialty Society Delegates and Alternates (n =452)	54.4	35.0%	6.9%	4.0%
Family Medicine Delegations (n =31)	53.4	38.7%	9.7%	6.5%
Internal Medicine Delegations (n =100)	54.5	35.0%	11.0%	7.0%
Surgery Delegations (n =101)	57.6	15.8%	5.0%	1.0%
Pediatrics Delegations (n =14)	54.5	78.6%	0.0%	7.1%
OB/GYN Delegations (n =26)	57.3	65.4%	3.8%	0.0%
Radiology Delegations (n = 34)	53.7	29.4%	5.9%	8.8%
Psychiatry Delegations (n =23)	52.7	39.1%	4.3%	0.0%
Anesthesiology Delegations (n =16)	54.1	31.3%	12.5%	0.0%
Pathology Delegations (n =22)	53.7	36.4%	9.1%	0.0%
Other specialty Delegations (n =85)	51.2	41.2%	4.7%	4.7%

¹ See Appendix B for a listing of specialty classifications.

Table 6. Mean Age of AMA Members and Delegations by State

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	2,988	51.4	8	61.8
Alaska	368	55.2	3	*
Arizona	4,473	54.4	11	61.5
Arkansas	2,036	52.2	5	61.4
California	31,805	54.6	60	53.9
Colorado	4,306	52.7	9	55.6
Connecticut	3,246	52.9	8	67.4
Delaware	610	55.6	2	*
District of Columbia	2,020	45.6	4	55.3
Florida	15,328	55.9	31	59.3
Georgia	5,811	52.1	11	60.5
Guam	25	58.5	1	*
Hawaii	1,086	56.0	3	*
Idaho	602	55.8	2	*
Illinois	11,391	51.4	23	60.5
Indiana	4,826	51.8	10	60.2
Iowa	3,233	52.0	7	53.0
Kansas	1,834	52.5	7	63.7
Kentucky	3,797	51.3	11	57.6
Louisiana	5,597	49.9	8	53.8
Maine	1,237	54.3	3	*
Maryland	5,330	53.8	10	54.6
Massachusetts	12,209	50.7	20	56.5
Michigan	12,013	50.2	27	56.4
Minnesota	4,708	52.1	11	62.0
Mississippi	2,357	52.0	6	54.8
Missouri	5,187	48.4	10	60.2
Montana	705	56.3	2	*
Nebraska	1,736	48.7	4	49.0
Nevada	1,523	53.6	5	70.2
New Hampshire	871	54.3	2	*
New Jersey	7,934	54.4	17	64.3
New Mexico	1,112	55.3	4	58.0
New York	20,229	52.0	35	60.6
North Carolina	5,140	51.9	8	59.8
North Dakota	780	50.1	1	*
Ohio	10,697	50.6	22	53.4
Oklahoma	3,501	52.3	8	65.0
Oregon	2,385	54.3	5	59.2
Other	1,140	62.4	N/A	N/A
Pennsylvania	12,136	51.4	27	58.1
Puerto Rico	1,523	54.9	2	*
Rhode Island	985	50.4	5	59.0
South Carolina	4,111	51.3	10	61.5

* To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
South Dakota	985	51.5	3	*
Tennessee	4,804	52.0	9	62.9
Texas	20,342	50.5	31	61.5
Utah	1,785	51.6	4	61.5
Vermont	424	52.8	2	*
Virgin Islands	33	64.8	0	N/A
Virginia	7,495	52.9	14	62.9
Washington	4,295	54.3	9	53.2
West Virginia	1,837	50.8	4	67.5
Wisconsin	4,511	52.4	9	63.2
Wyoming	213	58.2	2	*
TOTAL	271,655	53.1	555	59.1

Table 7. Women and International Medical Graduates on State Association Delegations

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	2,988	8	29.5%	0	11.5%	0
Alaska	368	3	37.2%	2	8.4%	0
Arizona	4,473	11	35.2%	2	15.0%	0
Arkansas	2,036	5	36.0%	1	12.1%	1
California	31,805	60	39.9%	15	17.8%	2
Colorado	4,306	9	40.2%	6	5.5%	0
Connecticut	3,246	8	39.6%	3	19.9%	1
Delaware	610	2	31.1%	2	22.1%	0
District of Columbia	2,020	4	50.4%	0	11.8%	0
Florida	15,328	31	33.3%	8	26.2%	4
Georgia	5,811	11	39.2%	2	16.6%	1
Guam	25	1	16.0%	0	44.0%	0
Hawaii	1,086	3	35.5%	1	12.8%	0
Idaho	602	2	23.3%	1	5.3%	0
Illinois	11,391	23	38.0%	7	23.0%	6
Indiana	4,826	10	33.2%	3	14.7%	2
Iowa	3,233	7	35.2%	2	18.1%	0
Kansas	1,834	7	30.8%	3	14.6%	1
Kentucky	3,797	11	35.4%	2	14.1%	0
Louisiana	5,597	8	40.8%	2	14.3%	1
Maine	1,237	3	43.9%	1	8.8%	0
Maryland	5,330	10	42.8%	6	22.0%	4
Massachusetts	12,209	20	46.6%	6	15.4%	1
Michigan	12,013	27	37.1%	8	20.4%	4
Minnesota	4,708	11	37.8%	4	12.6%	0
Mississippi	2,357	6	31.3%	3	7.7%	0
Missouri	5,187	10	36.8%	3	10.7%	2
Montana	705	2	38.6%	1	4.1%	0
Nebraska	1,736	4	38.0%	2	7.5%	0
Nevada	1,523	5	35.3%	1	17.5%	2
New Hampshire	871	2	35.2%	0	17.5%	0
New Jersey	7,934	17	36.9%	5	28.7%	3
New Mexico	1,112	4	37.9%	1	15.2%	0
New York	20,229	35	39.7%	5	27.4%	5
North Carolina	5,140	8	34.6%	4	12.4%	0
North Dakota	780	1	37.9%	1	17.3%	0
Ohio	10,697	22	38.3%	9	16.1%	1
Oklahoma	3,501	8	33.9%	1	11.2%	1
Oregon	2,385	5	35.8%	1	7.6%	0
Other	1,140	0	25.1%	0	41.4%	0
Pennsylvania	12,136	27	36.5%	6	16.2%	3
Puerto Rico	1,523	2	42.7%	0	20.3%	1
Rhode Island	985	5	41.9%	3	15.5%	0

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	4,111	10	40.0%	1	7.3%	0
South Dakota	985	3	34.5%	1	12.2%	0
Tennessee	4,804	9	34.1%	2	11.4%	2
Texas	20,342	31	39.4%	7	17.1%	2
Utah	1,785	4	27.7%	1	5.7%	0
Vermont	424	2	39.6%	1	6.6%	0
Virgin Islands	33	0	30.3%	0	42.4%	0
Virginia	7,495	14	41.2%	4	15.8%	1
Washington	4,295	9	36.8%	3	12.9%	1
West Virginia	1,837	4	36.1%	0	21.6%	0
Wisconsin	4,511	9	36.3%	3	16.0%	1
Wyoming	213	2	26.8%	0	10.3%	0
TOTAL	271,655	555	36.1%	156	16.0%	53

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section²
- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

² The Private Practice Physicians Section was established during the Special Meeting of the House of Delegates in November 2020. Data for section leaders was therefore not included in this report.

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-JUN-21

Subject: Council on Medical Education Sunset Review of 2011 House Policies

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association policies to ensure that our AMA’s policy database is current,
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and
4 specifying the needed procedures:
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10
10 years.
11
 - 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be
15 assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
16 asked to review policies shall develop and submit a report to the House of Delegates identifying
17 policies that are scheduled to sunset; (d) For each policy under review, the reviewing council
18 can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii)
19 retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For
20 each recommendation that it makes to retain a policy in any fashion, the reviewing council shall
21 provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the
22 House of Delegates to handle the sunset reports.
23
 - 24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
25 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy,
26 or has been accomplished.
27
 - 28 4. The AMA councils and the House of Delegates should conform to the following guidelines for
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
32 House of Delegates Reference Manual: Procedures, Policies and Practices.
33
 - 34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
35
 - 36 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Council on Medical Education recommends that the House of Delegates policies listed in the
4 appendix to this report be acted upon in the manner indicated and the remainder of this report be
5 filed. (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Texts	Recommendation
H-210.986	Physicians and Family Caregivers - A Model for Partnership	Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden; (2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care; (3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver. Citation: (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; duplicative of H-210.980, "Physicians and Family Caregivers: Shared Responsibility," which reads: "Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients."

D-295.322	Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools	Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. (Res. 313, A-09; Modified: CME Rep. 6, A-11)	Retain; remains relevant, especially due to increased attention to the need for diversity in medical education and practice.
H-295.888	Progress in Medical Education: the Medical School Admission Process	1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. 2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. (CME Rep. 8, I-99;	Retain; remains relevant, as the AMA's Accelerating Change in Medical Education initiative and other activities seek to improve the selection process for medical students (and change the composition and diversity of the future physician workforce).

		Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)	
H-305.962	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-305.962 , "Taxation of Federal Student Aid," which reads: "Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA)."
H-40.994	Military Physicians in Graduate Medical Education Programs	Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-40.995 , "Graduate Medical Education in the Military," which reads, in part: "Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; ... 5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of

			civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage.”
D-180.995	Physician Privileges Application - Timely Review by Managed Care	Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; still relevant.
D-255.982	Oppose Discrimination in Residency Selection Based on International Medical Graduate Status	Our AMA: 1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants. 2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience. 3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08; Reaffirmation I-11)	Rescind. Clause 1 is reflected in ACGME Institutional Requirement IV.1.5, “Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)” Clause 2 is superseded by H-255.988 (11), “AMA Principles on International Medical Graduates,” which reads, “That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an

			ethnic name as a negative factor.” Also reflected in H-255.983, “Graduates of Non-United States Medical Schools,” which reads, “The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.” Clause 3 was accomplished at the time of adoption of the resolution.
D-275.993	Reporting of Resident Physicians	Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, ~~consistent with existing AMA Policy H-265.934 (#4)~~; (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4-I-01; Reaffirmed CME Rep. 2-A-11)	Retain in part. Policy H-265.934 is no longer AMA policy, hence the deletion in clause 1.
D-305.992	Accounting for GME Funding	Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our	Retain; remains relevant. See also H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs”:

		AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11)	“4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.”
H-310.911	ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities	Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that “activities in organized medicine” facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11)	Retain; remains relevant. See also H-310.905 , “Scholarly Activity by Resident and Fellow Physicians.”
H-310.959	In-Service Training Examinations - Final Report	It is the policy of the AMA ~~(1)~~ to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; ~~(2)~~	Retain in part. Clause 1 is still relevant. For clauses 2 and 3, the Accreditation Council for Graduate Medical Education is using Milestones and multiple measures of evaluation.

		~~to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)~~	Relying on one metric is frowned upon. (see Sections V.A.1 Resident Feedback and Evaluation and V.A.2 Resident Final Evaluation.)
H-310.960	Resident Education in Laboratory Utilization	Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-310.996	Residency Review Committee Representation	Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; (3) requests that the resident members of the RRCs be peer-selected; and (4) will advocate for diversity of appointees to RRCs. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: Res. 304, A-11)	Rescind; is now reflected in ACGME documents, including ACGME Policies and Procedures, Subject: 9.00 Review Committees and Recognition Committee: “(8) Member Appointment – Nominating organizations should submit to the ACGME administration the names of two candidates for each vacancy at least 12 months before the date of the appointment. Nominating organizations should consider professional qualifications, geographic distribution, and diversity in nominating their candidates.” Also reflected in Committees and Members Selection

			Process: “Review Committees have physician members, at least one of whom is a resident at the time of appointment, and a public member. “Appointment of Resident Members to Review Committees “The process takes approximately 12 months from the call for nominations until the member’s term begins. The Review Committee Executive Director requests nominations through the ACGME e-Communication and/or via letter to the specialty-specific professional organizations that have resident groups.”
H-410.986	Resident Involvement in Practice Parameters	Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. The intent of this policy is being met, as many specialty societies include residents/fellows on committees on development of guidelines for physician practice.
D-140.981	Ethical Guidelines on Gifts to Physicians from Industry	Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to encourage the Liaison	Rescind. This directive has been accomplished.

		Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure databases that exist or will be created by 2013 as required by the Patient Protection and Affordable Care Act; and (5) work with AAMC and AACOM to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (Res. 13, A-02; Reaffirmed: Res. 303, A-05; Appended: Res. 308, A-11)	
H-275.993	Examinations for Medical Licensure	Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This is in essence the role of medical school faculties, and the essence of medical school accreditation.
H-295.868	Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training	1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs. 2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness. 3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians. 4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs. 5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG). 6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.	Retain in part. Still timely, with deletion of clauses 4-7, as these are no longer relevant.

		~~7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.~~ 48. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices. 59. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision. 640. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency. 744. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers. 842. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. (CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11)	
H-310.970	Mandatory Helicopter Flight for Emergency Medical Residents in Training	Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset	Rescind; superseded by H-295.943 , "Issues Regarding Patient and/or Donor Transports by Resident

		Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20)	Physicians and Medical Students.”
H-295.943	Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students	Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant. See also H-310.970 , “Mandatory Helicopter Flight for Emergency Medical Residents in Training,” which is being rescinded through this report, as it is superseded by H-295.943.
D-305.990	Impact of Health System Changes on Medical Education	Our AMA will continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; remains relevant, but superseded by H-305.942 , “The Ecology of Medical Education: The Infrastructure for Clinical Education,” which reads: “The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty

			distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians.”
D-405.987	Debilitating Accidents and Accidental Deaths of Physicians in Training	Our AMA: 1) requests modification in the annual survey distributed to medical schools in order to assess the topic of serious accidents and accidental deaths; 2) requests modification of other annual surveys of medical schools, residency directors, and other medical educators in order to assess the topic of serious accidents and accidental deaths among physicians in training. (Res. 323, A-11)	Rescind; this directive was accomplished.
H-435.997	Medical School Malpractice Risk Prevention Curriculum	Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed:	Rescind; superseded by H-295.924 , “Future Directions for Socioeconomic Education,” which reads: “The AMA: (1) asks medical schools and residencies to encourage that basic

		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."
G-615.060	CME Activities	Our AMA supports intensified efforts of the Council on Medical Education and other bodies within our AMA to initiate meetings and encourage continuing dialogue with medical students, interns, and residents. (Sub. Res. 22, I-69; CME Rep. I, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11)	Rescind; this work is already reflected in multiple AMA activities and initiatives, including the Medical Student Section and Resident and Fellow Section (neither of which were in existence in 1969, when this policy was adopted).
H-300.946	Inappropriate Use of Social Security	Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain	Retain; remains relevant.

	Numbers in CME Accreditation	continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01; Reaffirmed: CME Rep. 2, A-11)	See also H-190.963 , “Identity Fraud,” which reads: “Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation.”
D-300.980	Opposition to Increased CME Provider Fees	1. Our AMA will ~~(a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA’s requests this past year;~~ ~~(ab)~~ continue to work with the ACCME to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that ~~the updated~~ accreditation criteria improve patient care; and ~~(be)~~ continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, “Opposition to Increased Continuing Medical Education (CME) Provider Fees.” ~~3. Our AMA, in collaboration with the ACCME, will do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME. (CME Rep. 14, A-10; Appended: CME Rep. 9, A-11; Modified: CCB/CLRPD Rep. 4, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 302, A-17)~~	Retain in part. Delete 1.(a) and 3, which have been accomplished, and delete “updated” in 1.(b)(iv), in that these criteria were revised in the past. As stated in Council on Medical Education Report 7-A-12, the Council monitored results of the recommendations from Policy D-300.980 for the prior three years, and the Accreditation Council for Continuing Medical Education has been amenable to discussing AMA concerns. In December 2009, the ACCME created a task force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it continues to be actively engaged in ongoing discussions and that some of the “simplification” changes associated with

			the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME.
H-300.973	Promoting Quality Assurance, Peer Review, and Continuing Medical Education	Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.974	Unification of Continuing Education Credits	Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to <i>AMA PRA Category 1 Credit</i> ™. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01; Modified: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.975	Fraudulent/Legitimate Continuing Medical Education Activities	Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
D-300.979	Suggested Revision in	~~1. Our AMA will: (1) strongly encourage the Accreditation Council for Continuing Medical~~	Retain in part with the deletion of (1) and

	ACCME Evaluations	~~Education to recognize the value of gaining knowledge outside a physician's specialty and change the activity evaluation to reflect this;~~ and (2) communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians' knowledge and competence. (Sub. Res. 310, A-10; Appended: Res. 320, A-11)	editorial change to (2), along with the number 1., which is unneeded. Both (1) and (2) have been accomplished, but (2) is still relevant.
H-300.992	National Accreditation of AMA as Provider of Continuing Medical Education	Our AMA assigns to the ~~CME Council on Medical Education~~ the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant, with editorial change to specify the "Council on Medical Education," to avoid confusion with "continuing medical education."
D-300.995	Reducing Burdens of CME Accreditation and Documentation	Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; accomplished. In 2017, the AMA and ACCME completed a multi-year process of simplification and alignment of the credit and accreditation systems. The process included multiple avenues of input from the CME community, culminating in a call for comment regarding proposed changes. The recommendations of the AMA/ACCME bridge committee were approved by the AMA Council on Medical Education and the ACCME Board of Directors.
D-300.998	Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures	Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS	Retain; remains relevant.

		(CME Rep. 2, A-01; Reaffirmed: CME Rep. 2, A-11)	
H-250.996	Enhancing Young Physicians' Effectiveness in International Health	It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-260.978	Salary Equity for Laboratory Personnel	It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; outside the scope of the AMA.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights. 2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. (Res. 238, A-08; Appended: Res. 301, A-11)	Retain; still relevant. Note editorial change to clause 1 to fix error.
D-275.989	Credentialing Issues	~~1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.~~	Rescind in part. Clause 1 has been accomplished through work by the FSMB and ECFMG to replace paper-based processes with an electronic portal for medical school transmission of diplomas and transcripts for IMGs. These technological advances

		~~2-~~ Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials. (CME Rep. 3, A-02; Appended: CME Rep. 10, A-11)	have reduced turnaround time for credentials verification for the majority of applicants. Clause 2 should be retained, in that states should be encouraged to accept the ECMG certification as proof of primary source verification of an IMG's international medical education credentials, to ensure efficiency and reduced processing time for IMGs seeking licensure while protecting the public.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-JUN-21

Subject: Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (Resolution 311-A-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 311-A-19, “Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses,” introduced by the International Medical Graduates Section (IMGS), and referred by the House of Delegates, asked that our American Medical Association (AMA) work with the Federation of State Medical Boards (FSMB), the Organized Medical Staff Section, and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

Testimony on this item during the 2019 Annual Meeting from an international medical graduate (IMG) academic physician who has trained many residents and fellows in the United States, but who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from Florida testified how that state continues to grapple with the issue of physician immigrants from Cuba and other countries who do not meet state licensure requirements yet seek to find a way in which to put their (often considerable) skills to work in their new country in service to patients and society.

BACKGROUND

All state medical boards require physicians to have completed at least one year of graduate medical education (GME) in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) to be eligible for a full, unrestricted medical license.¹ Some states do issue limited, restricted licenses that allow a physician to practice, under supervision, in specific institutions. Some of these physicians are IMGs who not only received their medical education outside the U.S. but also trained in a specialty and practiced abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution utilizing one of these limited, restricted licenses, despite being ineligible for full licensure. Some institutions, however, have instituted changes to require that all physicians employed by the institution be board certified or board eligible. This has excluded physicians with restricted, limited licenses who may have been serving their community for years while contributing to patient care and the medical education of students and residents.

RESTRICTED LICENSES

Medical boards issue a variety of licenses other than full, unrestricted licenses. Of relevance, 40 medical boards issue “faculty/educational” licenses; 44 issue “limited/special purpose” licenses, and 19 issue “institutional practice” licenses.¹ Medical boards may determine the limitations or conditions of practice under these licenses differently, as well as the educational and/or training requirements. In addition, the boards use different names for possibly similar types of licenses, making it challenging to quantify less common license types at the national level. For example, according to a requested analysis provided by the FSMB, 163 physicians nationwide possess a license categorized as “teaching.” These licenses are labeled variously, such as “Foreign Teaching Physicians” or “Distinguished Faculty.” This count could be low considering the variability in how medical boards categorize and share data for these less common license types.

For example, in Washington state, the Washington Medical Commission may “issue a limited license to a physician applicant invited to serve as a teaching-research member of the institution’s instructional staff if the sponsoring institution and the applicant give evidence that he or she has graduated from a recognized medical school and has been licensed or otherwise privileged to practice medicine at his or her location of origin. Such license shall permit the recipient to practice medicine only within the confines of the instructional program specified in the application.”²

Texas offers a faculty temporary license, with similar requirements as Washington, with specific restrictions concerning the institution that can hire the physician (i.e., certain medical centers, Texas medical schools, or GME sponsors).³ The District of Columbia specifically offers licenses “for foreign doctors of eminence and authority.”⁴ New York offers a limited permit that can allow an IMG without U.S. GME to practice in a nursing home; state-operated psychiatric, developmental or alcohol treatment center; or incorporated, nonprofit institution for the treatment of the chronically ill, but only for up to four years.⁵

Florida offers a “house physician” license and provides a detailed description of the work that can be done, all under the supervision of a physician with an active, unrestricted Florida license. The license for house physicians does not require U.S. GME and seems to have relatively few requirements, i.e., types of institutions are not specified, nor time limits.⁶

BOARD CERTIFICATION REQUIREMENTS

The American Board of Medical Specialties (ABMS) acknowledges that there may be acceptable alternative pathways to initial certification for candidates who have not completed U.S. GME. Some ABMS member boards recognize alternative pathways, but others do not, due to the challenges associated with assessing equivalency of training for these medical specialties.⁷

The ABMS Position Statement on Alternative Pathways to initial certification defines the guiding principles for acceptable alternative pathways that do not meet the standard pathway (i.e., ACGME-accredited or Canadian-accredited GME). An ABMS workgroup is currently reviewing the ABMS Position Statement to determine if additional changes are required to ensure continued clarity.⁷

The ABMS stipulates that alternative pathway policies and procedures for initial certification should:

1. Be transparent, objective, equitable, and readily available to interested candidates and stakeholders;

2. Not be arbitrary or capricious to interested candidates and stakeholders;
3. Include the assessment of all six of the ABMS/ACGME core competencies;
4. Include the assessment of professional standing in adherence with the ABMS Professional Standing Policy; and
5. Adhere to Member Boards' existing Board Eligibility policies for both specialties and subspecialties, provided those policies adhere to the ABMS Board Eligibility Policies.

Sixteen boards offer pathways for internationally trained physicians; in particular, ten boards offer pathways for physicians practicing in the United States at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor); two boards will accept international training as meeting all of the training requirements on a case-by-case basis; and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. Two boards have established that training in Australia and New Zealand is equivalent to ACGME-accredited training; these boards will accept candidates who trained in those countries.

Twenty-two member boards accept all of a candidate's training in Canada (either accredited by the Royal College of Physicians and Surgeons of Canada [RCPSC], or by another body acceptable to the board). Of these, eleven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board).

Regardless of a member board's position on alternative pathways, it is the policy of the ABMS that, to be eligible for certification in any specialty or subspecialty and to maintain certification, a physician must have a full and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada.

EXPLORATION OF ALTERNATIVE PATHWAYS IN MINNESOTA

Minnesota's International Medical Graduate Assistance Program, operational since 2016, helps IMGs in the state obtain residency positions. One aspect of the program includes study of possible licensure changes that would allow qualified IMGs to practice in Minnesota. The Minnesota Department of Health, working with the Minnesota Board of Medical Practice and other stakeholders, proposed two possible strategies in 2018: the creation of an IMG Primary Care Integration license and an amendment to the medical practice act to include an exemption for practice in primary care in a rural or underserved area. Objectively qualified IMGs would be able to practice in areas experiencing primary care shortages without entering U.S. GME. The process includes passage of all licensure exams, demonstrating at least seven years of medical practice, participation in a six-month clinical experience, and an assessment that would culminate in a certificate that would allow work under supervision.

The program would require the commitment of an accredited assessor. Another concern is that these physicians would not be eligible for board certification and may encounter employment restrictions. Two major stakeholders—the Minnesota Academy of Physician Assistants and the Minnesota Medical Association—have raised objections, citing concerns over professional role confusion and a tiered licensure system. The Minnesota Department of Health continues to research possible licensure changes.^{8,9}

1 CURRENT AMA POLICY

2
3 As shown in the appendix, the AMA has substantial policy that supports full licensure for
4 practicing physicians, whether U.S. medical school graduates or IMGs, only after completion of at
5 least one year of GME in the U.S. (see H-255.988 [12] and H-275.934 [2]).

6
7 Policy H-160.949 (6) specifies as well that the AMA “opposes special licensing pathways for
8 physicians who are not currently enrolled in an [accredited]...training program.” This policy was
9 adopted at the 2014 Annual Meeting in response to development in Missouri of a special licensure
10 pathway for practice by “assistant physicians” who have not had any GME in the U.S. (see
11 [https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)
12 [rejects-assistant-physician-concept/](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)). Meanwhile, Policy H-275.978 (5) states that the AMA “urges
13 those licensing boards that have not done so to develop regulations permitting the issuance of
14 special purpose licenses. It is recommended that these regulations permit special purpose licensure
15 with the minimum of educational requirements consistent with protecting the health, safety and
16 welfare of the public.” It would seem that these two policies are contradictory; accordingly, they
17 are proposed for modification in the recommendations below.

18
19 In addition, the AMA both recognizes the value of board certification but advocates against
20 discrimination against physicians based on a lack of board certification. Policy H-220.960 asks The
21 Joint Commission to “support retention of important medical staff structural standards in its
22 hospital accreditation programs, including, but not limited to, standards...that board certification is
23 an excellent benchmark for the delineation of clinical privileges.” At the same time, H-275.926
24 states that the AMA “(4) Opposes discrimination against physicians based solely on lack of ABMS
25 or equivalent AOA-BOS board certification, or where board certification is one of the criteria
26 considered for purposes of measuring quality of care, determining eligibility to contract with
27 managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining
28 competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that
29 may occur against physicians involved in the board certification process, including those who are
30 in a clinical practice period for the specified minimum period of time that must be completed prior
31 to taking the board certifying examination.”

32 SUMMARY AND RECOMMENDATIONS

33
34
35 Existing AMA policy is of two minds in terms of the requirements for full licensure and board
36 certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for
37 access to health care services, must be balanced with requisite caution in awarding licensure for
38 practice, given the need to protect the public and ensure the quality of the medical workforce.
39 Given, however, that physicians who have been serving their communities for years may have their
40 careers jeopardized as a result of employers adopting new employment standards, the Council on
41 Medical Education recommends that the following recommendations be adopted in lieu of
42 Resolution 311-A-19 and the remainder of this report be filed:

- 43
44 1. That our American Medical Association (AMA) encourage state medical licensing boards and
45 the member boards of the American Board of Medical Specialties to develop criteria that allow
46 1) completion of medical school and residency training outside the U.S., 2) extensive U.S.
47 medical practice, and 3) evidence of good standing within the local medical community to
48 serve as a substitute for U.S. graduate medical education requirement for physicians seeking
49 full unrestricted licensure and board certification. (Directive to Take Action)

- 1 2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical
2 Graduates,” by addition to read as follows:
3
4 Our AMA supports ...12. The requirement that all medical school graduates complete at least
5 one year of graduate medical education in an accredited U.S. program in order to qualify for
6 full and unrestricted licensure. State medical licensing boards are encouraged to allow an
7 alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of
8 medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and
9 3) evidence of good standing within the local medical community. (Modify Current HOD
10 Policy)
11
- 12 3. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical
13 Boards Recommendations on Licensure,” by addition to read as follows:
14
15 2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools
16 or international medical graduates, must have completed one year of accredited graduate
17 medical education (GME) in the U.S., have passed all state-required licensing examinations
18 (USMLE or COMLEX USA), and must be certified by their residency program director as
19 ready to advance to the next year of GME and to obtain a full and unrestricted license to
20 practice medicine. State medical licensing boards are encouraged to allow an alternate set of
21 criteria for granting licensure in lieu of this requirement for completing one year of accredited
22 GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2)
23 extensive U.S. medical practice, and 3) evidence of good standing within the local medical
24 community. (Modify Current HOD Policy)
25
- 26 4. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by
27 addition and deletion to read as follows:
28
29 Our AMA ... (6) opposes special licensing pathways for “assistant physicians” (i.e., those who
30 are not currently enrolled in an Accreditation Council for Graduate Medical Education of
31 American Osteopathic Association training program, or have not completed at least one year of
32 accredited post-graduate US medical education in the U.S). (Modify Current HOD Policy)
33
- 34 5. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as
35 follows:
36
37 Our AMA ... (5) urges those licensing boards that have not done so to develop regulations
38 permitting the issuance of special purpose licenses, with the exception of special licensing
39 pathways for “assistant physicians.” It is recommended that these regulations permit special
40 purpose licensure with the minimum of educational requirements consistent with protecting the
41 health, safety and welfare of the public; (Modify Current HOD Policy)

Fiscal Note: \$1,000.

APPENDIX

H-160.949, "Practicing Medicine by Non-Physicians"

Our AMA . . . (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

H-220.960, "The Joint Commission Hospital Accreditation Program Standards"

Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges....

H-255.966, "Abolish Discrimination in Licensure of IMGs"

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

H-255.970, "Employment of Non-Certified IMGs"

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure.

H-255.988, "AMA Principles on International Medical Graduates"

Our AMA supports:

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

H-275.926, "Medical Specialty Board Certification Standards"

Our AMA: (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

H-275.934, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure"

Our AMA adopts the following principles: (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine.

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience....

H-275.978, "Medical Licensure"

Our AMA: (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

REFERENCES

- ¹ U.S. Medical Regulatory Trends and Actions 2018. Federation of State Medical Boards: 2018.
- ² Washington State Legislature, RCW 18.71.095. Limited licenses.
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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Optimizing Match Outcomes
(Resolution 304-I-19)
(Reference Committee C)

EXECUTIVE SUMMARY

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to the development of American Medical Association (AMA) policy and advocacy to increase residency training positions, and policy that promotes systems and programs to guide applicants to choose specialties and apply and match to residency training programs effectively. Recent technological problems with the application service used by unmatched applicants and unfilled training programs, the Supplemental Offer and Acceptance Program[®] or SOAP[®], have increased the apprehension of medical students and physicians concerning their ability to enter graduate medical education.

Many medical education stakeholders, most notably the Association of American Medical Colleges (AAMC), but also the National Resident Matching Program (NRMP) and the AMA, have developed numerous tools and informational guides to help students select a specialty and then apply to, interview with, rank, and match to programs. In addition, U.S. medical schools have dedicated staff eager to help students successfully match into residency programs, providing accessible online advice as well as personal counseling. To further improve the system, pilots are currently being tested to provide optimal matching opportunities with the intent of decreasing anxiety during the application/interview/matching season, reducing superfluous applications, and increasing transparency between applicants and programs.

In the interim, key stakeholder organizations, such as the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information consistently and rationally if the desire is to successfully match to a program.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-JUN-21

Subject: Optimizing Match Outcomes
(Resolution 304-I-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 304-I-19, “Issues with the Match, the National Residency Matching Program (NRMP),” introduced by the Indiana Delegation, asked the AMA to:

1. continue working to promote an increase in residency program positions in the U.S.;
2. study how residency programs can expand in novel ways;
3. determine what strategies can increase an applicant’s ability to match into a residency program;
4. support the option of permitting those who failed to obtain a position during the Supplemental Offer and Acceptance Program® (SOAP®) in 2019 to participate in a future matching opportunity at no cost; and
5. encourage the National Resident Matching Program (NRMP) and the Electronic Residency Application Service (ERAS) to conduct an audit to identify opportunities for lowering the financial burden on applicants and to promote and disseminate strategies to mitigate issues that interfere with successfully matching. The full resolution is in the Appendix.

Online and in-person testimony during the 2019 Interim Meeting suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, has already been addressed in the recent past by the Council on Medical Education (CME Report 3-A-16, “Addressing the Increasing Number of Unmatched Medical Students”). It was noted that the AMA has extensive policy on expanding graduate medical education (see for example D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education”). Testimony also noted that the NRMP and the Association of American Medical Colleges (AAMC) release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Others, however, expressed concern that current efforts to address this issue have been insufficient. The reference committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, but ultimately recommended referral of the entire resolution. The House of Delegates (HOD) subsequently agreed; this report is in response to that referral.

BACKGROUND

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to many resolutions presented to the AMA HOD and subsequent reports and policies generated to

address those concerns. This report: a) summarizes the AMA's recent efforts to increase residency training positions and assist applicants in applying to residency programs; b) describes the technological problems of SOAP in 2019 and what has been done to prevent future problems; and c) describes resources for applicants on effective program application and matching.

AMA REPORTS, POLICY, AND ADVOCACY

The AMA Council on Medical Education (CME) has prepared several reports for the HOD addressing the process of matching into residency programs, as well as the need to increase funding for graduate medical education (GME). For example, CME Report 3-A-18, "Expanding UME Without Concurrent GME Expansion," included three recommendations that were adopted as policy and recorded in D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education:"

(32) Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

CME Report 5-A-17, "Options for Unmatched Medical Students," outlined a number of key points related to unmatched medical students, including the long-term stability of match rates, common reasons for an unsuccessful match, options for students who do not match, and tools/initiatives from medical schools and medical organizations (including the AMA) to ensure an effective, efficient, and equitable match process that balances the interests of applicants and programs and promotes rational, strategic decision making by all parties. This report also highlighted AMA resources, including the AMA's Career Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs through FREIDA™. Another tool described in this report is the AAMC's Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond and provides self-assessment tools and specialty-specific data to inform those decisions.

CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," recommended reaffirming existing policy, namely D-305.967 (4) and (22), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education;" H-200.954 (4) (5) (6) and (7), "US Physician Shortage," and D-310.977 (11), "National Resident Matching Program Reform." These various policies direct the AMA to advocate for increasing GME positions; encourage research and data that support the value of GME; and encourage medical schools and residency programs to consider policies to attract physicians to practice in and care for patients in underserved and rural areas. Other policy encourages the AMA to work with other major stakeholders in medical education to evaluate data and propose new research that would describe how many students graduating from U.S. medical schools each year do not enter into a U.S. residency program; how many never enter into a U.S. residency program; whether there is

disproportionate impact on individuals of minoritized racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.

The AMA has long advocated for advancing GME, including increasing funding for residency positions, developing innovative funding models, and creating residency positions that reflect patient and societal needs. The AMA launched the Reimagining Residency Initiative in 2019 with \$15 million in grants to projects promoting systemic change in GME. Recently the AMA offered technical assistance in the drafting of the Health Heroes 2020 Act (H.R. 6650), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional \$25 billion for both the loan repayment and scholarship programs to increase the number of medical professionals in underserved communities. The Act would also increase the mandatory NHSC funding level from \$310M to \$690M for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards. The AMA offered assistance in the drafting of the Rural America Health Corps Act (S.2406) which builds upon the existing NHSC model by proposing up to five years of loan forgiveness (versus two) to help pay down medical school debt and increase the number of individuals that can enter the NHSC.

The AMA continues to voice its support for federal bills to increase residency positions, including the Resident Physician Shortage Reduction Act of 2021 (S. 834), which would expand Medicare funding for 15,000 additional residency positions. Earlier legislative proposals from 2019 that garnered AMA support and advocacy would close a loophole in GME cap-setting criteria affecting hospitals that temporarily host small numbers of residents (H.R. 1358), and provide 1,000 additional Medicare-supported GME positions over five years in hospitals that have, or are establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain management (H.R. 2439).

Most recently, there were multiple provisions in the new Appropriations Act that provide benefits for GME, variations of which AMA has advocated for, including:

- Increased funding (\$310 million) from 2021-2023 for the National Health Service Corps, and extended funding through 2023 for teaching health centers that operate GME programs. (Sec. 301)
- Hospitals will be allowed to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a per resident amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)
- A thousand additional Medicare-funded GME residency positions (200 per year for 5 years), to be distributed to rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126)

TECHNOLOGICAL PROBLEMS FOR SOAP

SOAP is a joint service of the NRMP and ERAS. Through SOAP, qualified applicants who do not obtain a position through the NRMP Match are privy to a list of participating programs that did not fill all their positions through the Match. Applicants submit applications to programs of interest. Programs review the applications and select candidates to interview (via phone, video, or in-person

if local), and positions are then offered to successful applicants. This occurs over a compressed timeframe, with three rounds over two days.

In 2019 the ERAS system experienced technical issues during the SOAP process, which affected applicants and program directors. The system was taken offline to correct the problem, resulting in a shortened time frame to complete the process; therefore, the NRMP reduced the number of rounds from three to two. The AAMC conducted an internal root-cause analysis and had an external review completed by an industry expert to evaluate technology and processes. Those reviews identified immediate and long-term steps that were implemented to mitigate future risk and to improve systems and operations.¹ Similar technical issues also occurred during the first day of the SOAP process in 2021. The cause of these issues was not known at the time this report was prepared, but the AAMC has apologized for the situation and promised another thorough investigation to understand the poor performance and identify and implement solutions to improve the process. The Council on Medical Education will continue to monitor the situation.

Typically, around 600 U.S. MD seniors are without a position at the conclusion of SOAP. In 2019, there were 623 without a position versus 620 in 2018. In 2020, there were 522. Overall, all applicants accepted offers with roughly the same frequency: the percent of offers accepted was 64.1 in 2018, 62.5 in 2019, and 61.8 in 2020.^{2,3,4} Data from the 2021 Match were not available at the time this report was prepared. Although the compressed schedule caused additional anxiety during a period that is normally stressful, the resulting proportions of applicants with positions are much the same. However, the NRMP has become concerned that in the past few years there has been a decrease in the number of SOAP-eligible applicants at the conclusion of the Match, compared to an increasing number of unfilled positions placed in SOAP, and an increasing number of unfilled positions at the end of SOAP. Coupled with the uncertainty surrounding the upcoming application and match season due to the COVID-19 pandemic, the NRMP has decided to add an additional, fourth offer round to the SOAP process.⁵

EFFECTIVE STRATEGIES FOR APPLYING AND MATCHING

The AAMC has numerous tools and informational guides developed to help students select a specialty and then apply to, interview with, and rank programs, all through the CiM website (<https://www.aamc.org/cim/>). Users of most CiM material need a subscription. Students of U.S. MD-granting schools have a subscription through their schools as a result of their school's membership in the AAMC. Students of DO-granting schools and international medical students may have subscriptions through their schools or may need to purchase an individual subscription for \$75. Medical school advisers also have access to CiM material.

The AAMC launched the Apply Smart website in 2016 to assist students in determining the optimal number of residency programs to which they should apply. The website provides information on the relationship between the number of applications submitted and the likelihood of entry into a residency program, highlighting the point at which the likelihood does not increase as the number of applications increase. Apply Smart also provides ranges of United States Medical Licensing Examination® (USMLE®) Step 1 scores as a comparison metric and suggests that students should consider limiting their applications at the point of diminishing returns.⁶ Although relatively easy to use and understand, there are some caveats to the tool's utility. The tool relies on USMLE 3-digit Step 1 scores, so students who do not have a Step 1 score, e.g., some students at DO-granting medical schools, will not find the tool useful. Future use of the tool when Step 1 results are reported as pass/fail (proposed to occur in January 2022) will also be in doubt, unless another valid metric is provided. Further, the tool's methodology has been questioned, in that the data uses the number of applications submitted through ERAS, which does not distinguish between

1 preferred specialties and backup specialties. Therefore, for example, a student may submit 10
 2 applications to a specialty that is not the preferred one and ultimately choose not to enter it. This
 3 datapoint will contribute to a low likelihood of entering that specialty with only 10 applications.⁷
 4 One suggestion is to pair ERAS applications data with interviews offered data, which, with the
 5 support of residency programs, is available through ERAS, thus creating a probability that a given
 6 number of applications results in an interview offer. Also suggested is pairing ERAS application
 7 data with NRMP data, to filter preferred specialties from backup specialties.⁷

8
 9 The AAMC has also developed the Residency Explorer tool, which uses Step 1 scores as well as
 10 Step 2CK and COMLEX-USA Level 1 and Level 2-CE scores. Offered free to U.S. medical and
 11 international students, Residency Explorer has benefited by creating a consortium of data
 12 providers. Users create a profile based on their test scores and academic achievements, and
 13 Residency Explorer will provide a list of programs in a chosen specialty with statistics on current
 14 and recent residents. Users can then compare where they stand in relation to matched residents at a
 15 given program. In addition, other characteristics about the program are provided for students to
 16 consider. Programs that have few residents or have been accredited for only a few years will not
 17 have test score information available and may also have few program characteristics to report. As
 18 with the Apply Smart tool, Step 1 three-digit scores will not be available once score reporting
 19 transitions to pass/fail; therefore, students of MD-granting schools will have one less metric.

20
 21 The NRMP produces several reports that can be helpful in guiding applicants' decision-making.
 22 The "Results from the Program Director Survey" describes what factors are considered by program
 23 directors, as well as their importance, when deciding which applicants to interview, and then the
 24 same for deciding how to rank applicants. The report is broken down by specialty. Unfortunately,
 25 the response rate by program directors to this survey is low, averaging 18 percent in 2019.⁸
 26 Similarly, the NRMP surveys applicants and asks about the program characteristics that influenced
 27 both application and ranking choices as well as the relative importance of those characteristics. In
 28 the "Results of the 2019 NRMP Applicant Survey by Preferred Specialty and Applicant Type"
 29 report, applying, interviewing, and ranking behavior is available by whether the applicant
 30 successfully matched or not. These data are also available by specialty. This report has a response
 31 rate of 42.3 percent, and specialties with fewer than 50 respondents are excluded.⁹

32
 33 More data on applicant characteristics and applying, interviewing, ranking, and matching success
 34 are available in the Charting Outcomes in the Match reports, available for U.S. MD seniors,¹⁰ U.S.
 35 DO seniors,¹¹ and graduates of international medical schools (IMGs).¹² All data are self-reported,
 36 with the exception of match data. These reports are also segmented into specialties. In addition, the
 37 NRMP used 2018 match data to create an interactive tool, the Interactive Charting Outcomes in the
 38 Match, which allows users to enter their own values, such as number of publications, and assess the
 39 percentage of applicants who matched or did not match, by Step 1 or Level 1 score range.¹³ Given
 40 the similarity to Residency Explorer, the NRMP has not further developed the interactive charts
 41 and collaborates with the AAMC on Residency Explorer.

42
 43 The AMA provides general guidance offered by experts in the field on choosing a specialty and
 44 effective applying and matching strategies, most of which can be found on the AMA website ("The
 45 Match journey made simple," at <https://www.ama-assn.org/residents-students/match/match-journey-made-simple>). The AMA has also developed a new residency calculator tool to help
 46 students estimate the costs of applying to programs (<https://freidaresidencycalculator.com/>).
 47
 48

49 Aside from the AAMC and the AMA, other websites provide advice on residency program
 50 applications and interviews. Many of these are geared in particular to IMGs, but not always, and
 51 may charge a fee for assistance. Specialty societies also present information on program locations

1 and characteristics and advice on how to apply to programs in the specialty, such as family
2 medicine (<https://www.aafp.org/medical-school-residency/residency/process.html>).
3

4 Finally, U.S. medical schools have dedicated staff that are eager to help students successfully
5 match into residency programs, providing accessible online advice as well as personal counseling.
6 The most commonly reported reason why a student does not successfully match is that the
7 student's academic performance (e.g., clinical grades) and/or USMLE scores are below the norm
8 for the desired specialty. Other commonly cited reasons are 1) applications in a single specialty, 2)
9 lack of a backup plan, and 3) application to too few programs. These issues could be mitigated with
10 advice, but some advisers report that some students do not make themselves available for career
11 counseling.¹⁴
12

13 *Pilots for 2021*

14

15 The Otolaryngology Program Directors Organization, the Society of University Otolaryngologists,
16 and the Association of Academic Departments in Otolaryngology created a voluntary signal
17 preference program in advance of the 2021 match, modeled after the preference signaling program
18 developed by the American Economic Association (AEA) to facilitate interview offers for
19 economics graduate students. In the AEA model, students can send signals to up to two employers
20 to indicate their interest in receiving an interview. Signals were found to increase probability of
21 interviews, especially for niche scenarios (e.g., an applicant whose academic and personal
22 background is limited to a single state or region may be viewed as unlikely to move to a different
23 geographic region and therefore an interview may not be offered despite excellent qualifications of
24 the applicant. A signal in this scenario changes the program's erroneous perception of applicant
25 disinterest). The otolaryngology pilot allows applicants to signal up to 5 programs. The signals will
26 be sent to participating programs around the time programs download applications from ERAS.
27 Participating programs are advised to consider signals of interest as one factor in a holistic review
28 of all applications and should not rely on signals to screen applications. In addition, programs
29 should expect many non-signaled applications from interested and highly qualified applicants.
30 Applicants were instructed not to signal their home institution or any programs at which they have
31 completed a clinical subinternship in the current calendar year, and programs were advised not to
32 expect to receive a signal from applicants in these scenarios.¹⁵ Examining ERAS data does not
33 suggest a reduction in the number of applications per applicant to otolaryngology programs
34 compared to previous years.¹⁶ It is not known publicly at this time how many programs and
35 applicants participated in the pilot.
36

37 The Association of Professors of Gynecology and Obstetrics and the Council on Resident
38 Education in Obstetrics and Gynecology have created the "Right Resident, Right Program, Ready
39 Day One" pilot program for the obstetrics and gynecology specialty. The program received a
40 \$1.75M grant from the AMA's Reimagining Residency Initiative. Aspects of the program include a
41 uniform application deadline date across all programs, limiting interview invitations to the number
42 of interview slots available, allowing a minimum of 72 hours for applicants to respond to an
43 interview invitation, and providing interview status (invited, waitlisted, or rejected) to all applicants
44 by November 22, 2020.¹⁷ In addition, the pilot program will develop an applicant compatibility
45 index mobile device application that facilitates alignment between applicants' profiles and
46 residency program offerings, and develop additional application review metrics for programs to use
47 in screening. The goal is to increase transparency and efficiency in the process to reduce costs and
48 anxiety and ultimately to increase individuals' success in training.¹⁸

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Resolution 304-I-19 contained a wide variety of requests for action, including some in which the AMA is currently engaged. The AMA continues to advocate for an increase in GME positions, innovative models of GME training, and greater accountability overall in the funding for and outcomes of GME. The AMA has studied the causes of failures to match into a residency program—as have many medical education stakeholders—and has made resources available to students that can reduce the risk of failure (again, as have many medical education stakeholders). Other actions requested in the resolution are already reflected in material and tools prepared by the AAMC and NRMP. This information, however, is not all in one location. Furthermore, availability and ease of access to known successful strategies will not help applicants who do not avail themselves of advice that runs counter to their own sense of identity as a practitioner of a particular specialty.

Current proposals in the literature to improve the process of applying to, interviewing with, and matching to residency programs include, among many, signaling program preference in the application,¹⁹ multi-phase matches,^{20,21} and capping the number of applications so that each applicant can be considered more holistically.²² The recent decisions of the Federation of State Medical Boards and the National Board of Medical Examiners, and the National Board of Osteopathic Medical Examiners, to report results of the USMLE Step 1 and the COMLEX-USA Level 1 examinations, respectively, as pass/fail rather than a three-digit score will remove metrics relied on by many individual program directors and application tools as a measure easily obtained and understood, although questionable in its ability to predict clinical performance. The application and interview season for the 2021 Match presented its own challenges, as programs were encouraged to interview applicants through video to reduce exposure to COVID-19. Few programs are experienced using virtual interviews, and most that have, have used them as adjunct to in-person interviews.²³ Programs were also encouraged to provide more information on the type of resident they are looking for, beyond academic statistics and overused adjectives. This is essential insight for students, who need to know when making their decisions to apply as to how well they would fit a given program.

Movement is afoot to revise the current system for program application, interviewing, and matching. In the interim, key stakeholder organizations, like the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information rationally if the desire is to successfully match to a program without unnecessary financial cost.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-I-19 and the remainder of this report be filed:

1. That our AMA reaffirm Policies D-310.977, “National Resident Matching Program Reform,” H-200.954, “US Physician Shortage,” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” (Reaffirm HOD Policy)

- 1 2. That our AMA encourage the Association of American Medical Colleges, American
2 Association of Colleges of Osteopathic Medicine, National Resident Matching Program,
3 and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of
4 reliable and valid advice and tools for residency program applicants seeking cost-effective
5 methods for applying to and successfully matching into residency. (Directive to Take
6 Action)

Fiscal note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

D-310.977, "National Resident Matching Program Reform"

Our AMA:

- (1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
- (5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
- (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
- (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
- (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
- (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

H-200.954, "US Physician Shortage"

Our AMA:

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

(c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
(Resolution 308-I-19)
(Reference Committee C)

EXECUTIVE SUMMARY

International medical graduates (IMGs) currently represent a quarter of the physician workforce and physicians-in-training in the United States. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations, and their foreign language proficiency can be invaluable when communicating with patients from the same country of origin. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce. This diversity is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, which assures the quality of the medical workforce and protects the public. That said, some licensing regulations, such as attaining source documents to verify one's medical education or other schooling, may be more challenging for IMGs than for physicians who graduated from medical schools in the U.S. Improving and streamlining licensing and credentialing policies and processes, where appropriate, can ensure that IMGs can help address health care inequities and improve health care access through service in federally designated health care shortage areas.

The goal of this report, which is in response to American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," is to "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA."

This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas. This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. New models, such as those described in this report, may enable physicians to be credentialed and licensed in a more efficient and timely manner in an effort to address national or international pandemics or medical emergencies at a state or regional level. The Council on Medical Education believes that states remain best positioned to evaluate the relative success of these programs in addressing their needs. In addition, successful efforts to reduce medical licensing barriers should be shared as best practices across states.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-JUN-21

Subject: Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
(Resolution 308-I-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice,” asks that our AMA “study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.” This report is in response to that policy.

INTRODUCTION

There is a projected shortage of physicians in the United States, given the aging of the present physician and general civilian populations, as well as potential and ongoing crisis situations, such as the COVID-19 pandemic, which has spiked the need for patient care and hospital beds across the country.¹ Compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. IMGs represent nearly one-quarter of the U.S. physician workforce. They often practice at institutions that are on the front line of the COVID-19 pandemic, and these physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Appendix A displays the U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state.

The continued steady influx of immigrants from strife-torn regions of the world to the U.S. includes highly trained physicians fleeing their country because of political or religious persecution. These immigrant physicians may have beneficial skills, such as professional experience and language proficiency. However, IMGs often face licensing barriers beyond those of physicians who graduated from a U.S. medical school. IMGs often are required to repeat complete cycles of training, including medical school, residency, and subspecialty training. This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas.

This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

CREDENTIALING REQUIREMENTS

Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is the standard for evaluating the qualifications of IMGs before they enter U.S. residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG requirements include examinations in the medical sciences, evaluation of English language proficiency, and documentation of medical education credentials.²

Non-U.S. citizen IMGs who seek entry into U.S. graduate medical education (GME) programs must obtain a visa permitting clinical training to provide medical services. The ECFMG / Foundation for Advancement of International Medical Education and Research Exchange Visitor Sponsorship Program (EVSP) serves as the visa sponsor for approximately 12,000 IMGs at teaching hospitals in the U.S.³⁻⁴ All non-U.S. citizen IMGs enter the U.S. in one of two broad immigration categories—either under a temporary, nonimmigrant visa or as a permanent resident. The two most common temporary, nonimmigrant classifications for IMGs are the J-1 Exchange Visitor program and the H-1B temporary worker classification. Both classifications limit a physician's duration of residence in the U.S. and impose strict controls over the range of employment authorized. In contrast, permanent residence provides a foreign national with both an unlimited duration of residence in the U.S. and authorization of full, unrestricted employment. However, the lead time required to qualify for permanent residence status is usually substantially longer than the lead time required to obtain temporary worker status.⁴ Additional information about visa options for IMGs is provided in Appendix B.

Certification from the ECFMG is a requirement for medical licensing, and it is a prerequisite for taking the United States Medical Licensing Examination (USMLE) Step 3. However, state licensure requirements vary from state to state.⁵ All state licensing jurisdictions require IMGs to complete at least one year of accredited U.S. or Canadian GME before licensure. However, 21 states require two years, and 27 states require three years of accredited GME.⁵

Some states issue limited, restricted licenses that allow IMGs who have not entered U.S. GME to practice in the U.S. under supervision and in specific institutions. To qualify, IMGs must have been trained in a specialty and practiced medicine abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution, despite being ineligible for full licensure. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about states that issue restricted licenses.)

Many institutions also require that physicians be board-certified or board eligible. However, it is the policy of the American Board of Medical Specialties (ABMS) that to be eligible for certification in any specialty or subspecialty and to maintain certification a physician must: 1) complete ACGME-accredited or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited GME; and 2) hold a full and unrestricted license to practice medicine in at least one jurisdiction in the U.S., its territories, or Canada. Some of the ABMS member boards recognize alternative pathways that may meet eligibility requirements for initial board certification for candidates who have not completed U.S. or Canadian-accredited GME.

Recognized alternative pathways for international trainees that may meet eligibility requirements include Canadian and international training. Twenty ABMS member boards accept all of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board) and of these, seven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada

(either accredited by the RCPSC or by another body acceptable to the board). Fifteen boards offer pathways for non-Canadian internationally trained physicians. Of these, nine boards offer pathways for physicians practicing in the U.S. at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor). Two boards will accept international training as meeting all training requirements on a case-by-case basis, and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. (Refer to CME Report 2, June 2021, “Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses,” for more information about board certification pathways.)

On January 26, 2021, the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, [announced](#) the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS) and henceforth the discontinuation of Step 2 CS, while continuing to seek innovative and sensible ways to assess medical licensing eligibility. ECFMG continues to oversee requirements for its certification of IMGs and [announced](#) an expansion of its pathways allowing qualified IMGs to meet the requirements for ECFMG Certification and continue to pursue U.S. graduate medical education.

AMA ADVOCACY ACTIVITIES DURING COVID-19 RELATED TO IMGs

The AMA has been especially active in its federal level advocacy efforts on behalf of IMG physicians during the COVID-19 pandemic. Some of the areas in which AMA advocacy has been most significant include visas, labor condition applications, work surrounding last year’s presidential proclamations, and the HEROES Act.

Visa Processing, Allocation, and Extensions

On March 20, 2020, U.S. Citizenship and Immigration Services (USCIS) suspended premium processing for visas. As such, IMG physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a [letter](#) to USCIS urging USCIS to reconsider the suspension and instead expand premium processing for H-1B visas. USCIS reopened its offices and resumed citizenship ceremonies in June 2020. Additionally, it restarted premium processing for certain visa petitions, including H-1B visas, in phases throughout June. Moreover, companies were allowed request accelerated processing for immigrant worker visas, and employers who had pending H-1B temporary worker visas could ask for their applications to be fast-tracked. Per the [USCIS website](#), premium processing for H-1B visa holders is available.

As the severity of the COVID-19 pandemic increased, embassies and consulates around the world stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In response, the AMA sent a [letter](#) to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting opening of visa processing at embassies and consulates for physicians joining U.S. residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin [processing visa applications](#) for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S. The AMA also confirmed that J-1 physicians can engage in revised clinical training rotations/assignments, in keeping with the ACGME’s [“Response to Pandemic Crisis.”](#)

1 IMG physicians were also concerned about alterations in work schedules and the visa
2 consequences of being laid off due to the impact of the COVID-19 pandemic. To help ease these
3 concerns, on April 14, 2020, the AMA sent a [letter](#) urging USCIS to recognize the COVID-19
4 pandemic as an extraordinary circumstance beyond the control of non-U.S. citizen IMG applicants
5 or their employers. The AMA consequently asked to expedite approvals of extensions and changes
6 of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In
7 addition, the AMA urged the Administration to extend the 60-day maximum grace period to a 180-
8 day grace period to allow any non-U.S. citizen IMG who had been furloughed or laid off as a result
9 of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked
10 USCIS to protect the spouses and dependent children of H-1B physicians by automatically granting
11 a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS
12 [announced](#) that it is temporarily waiving certain immigration consequences for failing to meet the
13 full-time work requirement due to quarantine, illness, travel restrictions, or other consequences of
14 the pandemic.

15
16 Throughout the pandemic, the AMA has not lost sight of the need for long term policy change,
17 especially change surrounding the need for an increase in visas for additional physicians. As such,
18 on May 8, 2020, the AMA sent letters to the U.S. [House of Representatives](#) and the U.S. [Senate](#)
19 supporting the “Healthcare Workforce Resilience Act” and urging the Congress to quickly pass the
20 legislation so that the U.S. can recapture 15,000 unused employment-based physician immigrant
21 visas from prior fiscal years. The bill was not enacted.

22 23 *Labor Condition Applications*

24
25 Labor Condition Application restrictions have made it difficult for IMGs to practice in areas where
26 they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a [letter](#) to
27 then Vice President Pence and USCIS urging the Administration to permit non-citizen IMG
28 physicians currently practicing in the U.S. with an active license and an approved immigrant
29 petition to apply and quickly receive authorization to work at multiple locations and facilities, with
30 a broader range of medical services, for the duration of the COVID-19 pandemic. The AMA also
31 urged the Administration to expedite work permits and renewal applications for all IMG physicians
32 who are beginning their residencies or fellowships or are currently in training. Due in part to the
33 advocacy efforts of the AMA, USCIS [announced](#) that IMGs can deliver telehealth services during
34 the current public health emergency without having to apply for a new or amended Labor
35 Condition Application. At the time of the writing of this report, the AMA is not planning additional
36 follow up on the Labor Condition Application.

37 38 *Presidential Proclamation*

39
40 As a result of the April 22, 2020 Presidential [Proclamation, Suspending Entry of Immigrants Who](#)
41 [Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19](#)
42 [Outbreak](#), the AMA sent a [letter](#) to then-Vice President Pence urging the Administration to allow
43 IMGs with J-1, H-1B, and O-1 (individuals with extraordinary ability or achievement) visas to be
44 exempt from any future immigration bans or limitations, so that these physicians can maintain their
45 lawful non-immigrant status while responding to the pandemic.

46
47 On June 22, 2020, President Trump issued a [Proclamation, Suspending Entry of Aliens Who](#)
48 [Present a Risk to the U.S. Labor Market Following the Coronavirus Outbreak](#). In response to the
49 proclamation, the DoS issued a [statement](#) that “as resources allow, embassies and consulates may
50 continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa
51 categories include applicants who may be eligible for an exception under these presidential

proclamations, such as...certain medical professionals.” As such, on June 26, 2020, the AMA sent a [letter](#) to the DHS and the DoS strongly urging the Administration to consider J-1 and H-1B IMGs and their families’ entry into the U.S. to be in the national interest of the country, so that families could remain together and IMG physicians could immediately begin to provide health care services to U.S. patients. The AMA understands that every physician is mission-critical, especially at this time.

Moreover, on July 8, 2020, the AMA initiated a sign-on [letter](#) for medical specialty societies. The letter urges the DoS and DHS to issue clarifying guidance pertaining to the June 22, 2020, proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members’ entry into the U.S. is in the national interest.

During his first day in office, President Biden issued a [Proclamation on Ending Discriminatory Bans on Entry to The United States](#) to revoke Executive Order 13780 of March 6, 2017 (Protecting the Nation From Foreign Terrorist Entry Into the United States), Proclamation 9645 of September 24, 2017 (Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), Proclamation 9723 of April 10, 2018 (Maintaining Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), and Proclamation 9983 of January 31, 2020 (Improving Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats).

On January 25, 2021, President Biden issued a [Proclamation on the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease](#) to further examine certain current public health precautions for international travel and take additional appropriate regulatory action, to the extent feasible and consistent with Centers for Disease Control and Prevention guidelines and applicable law.

HEROES Act

H.R. 6800, the “Health and Economic Recovery Omnibus Emergency Solutions Act” (HEROES ACT), is the U.S. House of Representatives’ next proposed coronavirus relief fund package and incorporates many of the IMG advocacy requests, including authorization of the Conrad 30 Program, expedited visa processing, and employment authorization cards for IMGs. For more information, see [sections](#) 191201 and 191204 of the HEROES Act or the AMA HEROES Act [Summary](#). The AMA has worked with members of the U.S. House of Representatives to help ensure that favorable measures for IMGs are included in this proposed legislation. At the time of the writing of this Council report, the HEROES ACT had been passed in the House and was sent to the Senate. It was assigned to the Committee on Small Business and Entrepreneurship and hearings were held but no action was taken. The Continuing [Appropriations Act](#) (H.R. 8337) was passed; however, it had very little in it concerning IMGs. The most recent stimulus bill, the [American Rescue Plan](#), does not include anything related to IMGs.

Additional Rule Changes

In the latter part of 2020, the AMA commented on related rule changes/proposed rule changes. Information regarding these rules and comments are located in Appendix C.

1 *IMG Resource Guide*

2
3 Due to the uncertainty that IMGs are experiencing during this time, the AMA has created an IMG
4 resource guide, [“FAQs: Guidance for international medical graduates during COVID-19.”](#) This
5 guide answers some of the most pressing questions IMGs have surrounding their ability to practice
6 and visas. It also lists available resources for assistance.
7

8 REVISIONS TO STATE LICENSURE REQUIREMENTS DURING COVID-19

9
10 In areas where physicians were acutely needed to address the needs of the patient surges during the
11 pandemic, state agencies created stratification processes for those non-U.S. citizen IMG physicians
12 most easily integrated into the system. These were IMGs working under direct supervision of
13 licensed physicians and identified on the basis of education, training, certification as a medical
14 specialist, English proficiency, and experience in direct patient care in countries other than the U.S.
15 For example, in 2020 the New Jersey Division of Consumer Affairs had been authorized to issue
16 temporary state medical licenses to IMGs who are licensed and in good standing in other countries,
17 along with other workforce measures. In January 2021, it was announced they were no longer
18 accepting new applications and pending applications were put on hold per review of the program.⁶
19 In New York, a March 23, 2020 executive order from Governor Cuomo allows non-US citizen
20 IMGs who are not licensed in the state but have completed at least one year of GME in the U.S., to
21 provide patient care in hospitals, under the supervision of a New York State-licensed and registered
22 physician, by way of a limited permit. This order was extended until May 6, 2021.⁷⁻⁸
23

24 PROGRAMS THAT SERVE AS MODELS FOR ACCELERATED TRAINING AND 25 CREDENTIALING

26
27 Programs such as the National Health Service (NHS) of Scotland show it is possible to retrain
28 immigrant physicians in 18 to 24 months, and that these physicians are able to demonstrate
29 proficiency in language, medicine, and the culture of the host country. Immigrant physicians in
30 Scotland who have been retrained on an accelerated path and who have demonstrated proficiency
31 in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the
32 NHS specific areas of need.⁹
33

34 Similarly, the following states are studying and developing pathways for qualified IMGs to
35 expeditiously enter practice in the U.S.
36

37 *Minnesota*

38
39 The Minnesota Department of Health (MDH) has supported the integration of IMGs through the
40 state’s International Medical Graduate Assistance Program.¹⁰ As the first program of its kind in the
41 U.S., the Minnesota Legislature established this program in 2015 to address barriers to practice and
42 facilitate pathways for immigrant IMGs to integrate into the Minnesota health care delivery system,
43 with the goal of increasing access to primary care in rural and underserved areas of the state. It has
44 achieved considerable success, including forming grant agreements with nonprofits to provide
45 career support to IMGs and working with residency directors to carve out pathways for IMGs to
46 demonstrate the clinical expertise required to enter into residency programs. The program requires
47 that participants be legal residents who have lived in Minnesota for at least two years, graduated
48 from an accredited medical school outside the U.S., and are willing to practice primary care in the
49 state’s underserved communities in rural and urban areas.

In its [2018 report](#), the MDH reported that the program has developed a database comprised of immigrant IMG physicians in Minnesota. The program also identified barriers to residency, and it is taking steps to address those barriers with the following interventions: funding dedicated residency positions for immigrant IMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support. The MDH report includes data on IMGs who received career guidance and support as well as those who were selected by the University of Minnesota Medical School to participate in the clinical experience component, which began in September 2017.

The MDH met with the Minnesota Board of Medical Practice and other stakeholders to study possible changes to the Medical Practice Act. The group proposed two possible strategies: an IMG Primary Care Integration License and an amendment to the Medical Practice Act, which would include an exemption for practicing primary care in a rural or underserved area. As noted in the 2018 MDH report, the creation of this alternate license would be beneficial because it would allow objectively qualified IMGs into the system quickly to address issues of health disparities and primary care shortages. It would not require additional residency positions and thus would be cost-effective. The process would require that IMGs pass all licensure exams, demonstrate previous work of at least seven years in medical practice, participate in a six-month clinical experience, and undergo an assessment. This process would culminate in a certificate allowing work under supervision.

Implementation of this proposal raised several concerns. This effort is based on identifying and securing the commitment of an accredited assessor. In addition, these IMGs would not be eligible for board certification and may encounter employment restrictions. Key stakeholders, including the Minnesota Medical Association and Minnesota Academy of Physician Assistants, have raised objections, citing concerns over a tiered licensure system and professional role confusion. The MDH continues to research possible licensure changes.¹¹⁻¹³

THE CONRAD 30 J-1 VISA WAIVER

IMGs who graduate from U.S. residency and fellowship programs may be in search of hospitals and practice groups that will support them in continuing their careers in the U.S. If these physicians held a J-1 Exchange Visitor visa during their GME in the U.S., they are required to return to their home countries for a two-year period before they can continue their careers in the U.S., but this provision can be waived in specific instances. One common way to do so is through the Conrad 30 Program, whereby a hospital or health center makes an application to a state department of health, requesting that the two-year home residency requirement be waived in exchange for the physician's three years of service in a medically underserved or health professional shortage area. The program currently allows for 30 waivers per state per year. However, the details of this annual program differ by state. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities.¹⁷

A study conducted by the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center, University of Washington, showed that Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.¹⁷ Since at least 2013, there have been efforts to make the Conrad 30 J-1 visa waiver program for physicians permanent; as this has yet to occur, it has been necessary to reauthorize the program every year. In 2019, bill was introduced in Congress to improve and extend the program until 2021—the *Conrad State 30 and Physician Access Reauthorization Act*.¹⁸ The bill was not enacted.

1 The AMA has been vocal in its support for the Conrad 30 program over the years. Recently, the
2 AMA worked with U.S. Senator Amy Klobuchar and a bipartisan list of other U.S. Senators to
3 show the impact of the Administration's immigration policy changes during the pandemic to IMGs,
4 reiterating the value of the Conrad 30 program and the need for its reauthorization.

5 6 RELEVANT AMA POLICY

7
8 The AMA has extensive policy regarding the requirements to practice medicine in the United
9 States. AMA Policy H-255.983 states that "the AMA continues to support the policy that all
10 physicians and medical students should be evaluated for purposes of entry into graduate medical
11 education programs, licensure, and hospital medical staff privileges on the basis of their individual
12 qualifications, skills, and character." Policy H-275.934 (2) states, "All applicants for full and
13 unrestricted licensure, whether graduates of U.S. medical schools or international medical
14 graduates, must have completed one year of accredited graduate medical education (GME) in the
15 U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified
16 by their residency program director as ready to advance to the next year of GME and to obtain a
17 full and unrestricted license to practice medicine." Policy H-255.966 (1.D.) notes, "U.S. states and
18 territories retain the right and responsibility to determine the qualifications of individuals applying
19 for licensure to practice medicine within their respective jurisdictions." Policy H-255.985 (1)
20 states, "Any United States or alien graduate of a foreign health professional education program
21 must, as a requirement for entry into graduate education and/or practice in the United States,
22 demonstrate entry-level competence equivalent to that required of graduates of United States
23 programs." Policy H-255.988 states that the AMA "continues to support the activities of the
24 ECFMG related to verification of education credentials and testing of IMGs."

25
26 At the Special Meeting of the AMA House of Delegates in November 2020, Policy D-275.950
27 "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US
28 Medical Graduates: Call for Expedited Action by the American Medical Association" was adopted.
29 In part it asks that the AMA "in collaboration with the Educational Commission for Foreign
30 Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for
31 international medical graduates to demonstrate clinical skills competency." Other related policies
32 are shown in Appendix D.

33 34 SUMMARY AND RECOMMENDATIONS

35
36 IMGs currently represent a quarter of the physician workforce and physicians-in-training. They
37 have long been an integral part of the U.S. health care system, contributing substantially to primary
38 care disciplines and providing care to underserved populations. The diversity of IMGs contributes
39 to the many ethnicities and cultures represented in the health care workforce.¹⁹ This is likely to be a
40 factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient
41 population. In addition, IMGs are serving on the front lines of patient care during the COVID-19
42 pandemic.

43
44 IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, but
45 some licensing regulations may be more challenging for IMGs than for U.S.-educated physicians.
46 There are, however, ways to improve and streamline licensing and credentialing policies and
47 processes to ensure that IMGs can be recruited to federally designated health care shortage areas to
48 address health care inequities and improve health care access. The AMA continues to assist IMGs
49 through its International Medical Graduates Section and advocacy efforts. Proposed and enacted
50 state models, such as those described in this report, may enable physicians to be quickly
51 credentialed and licensed in an effort to address national or international pandemics or state/

1 regional medical emergencies. States remain best positioned to evaluate the relative success of
2 these programs in addressing their needs; however successful efforts to reduce medical licensing
3 barriers should be shared among state licensing boards as best practices.

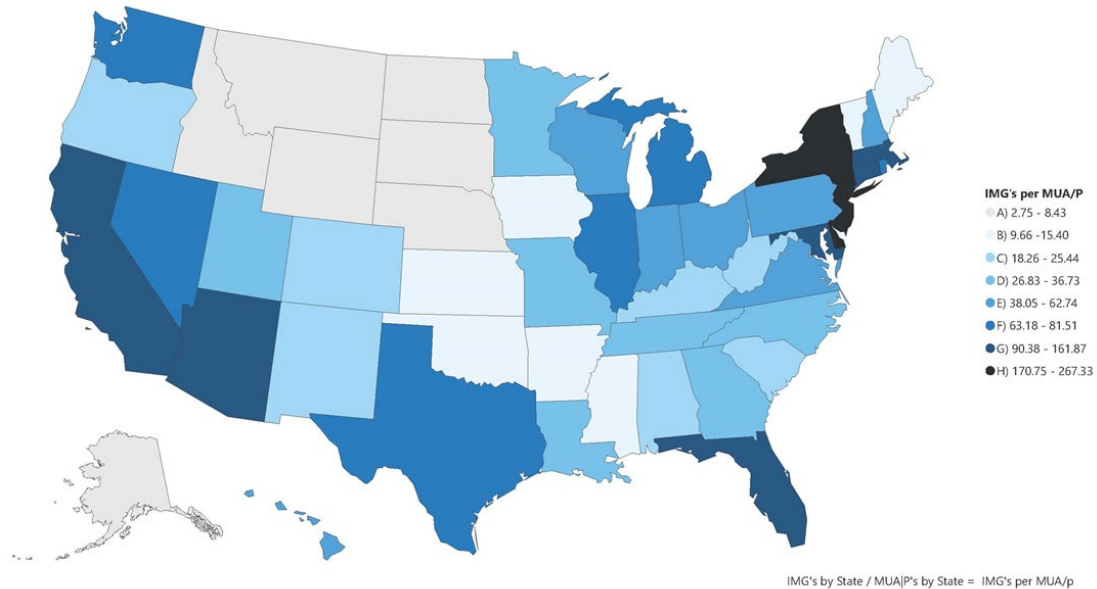
4
5 The Council on Medical Education therefore recommends that the following recommendations be
6 adopted and that the remainder of the report be filed:

- 7
8 1. That American Medical Association (AMA) Policy D-255.980 (1), “Impact of Immigration
9 Barriers on the Nation’s Health,” that reads, “Our AMA recognizes the valuable contributions
10 and affirms our support of international medical students and international medical graduates
11 and their participation in U.S. medical schools, residency and fellowship training programs and
12 in the practice of medicine” be reaffirmed. (Reaffirm HOD Policy)
13
14 2. That our AMA encourage states to study existing strategies to improve policies and processes
15 to assist IMGs with credentialing and licensure to enable them to care for patients in
16 underserved areas. (Directive to Take Action)
17
18 3. That our AMA encourage the Federation of State Medical Boards and state medical boards to
19 evaluate the progress of programs aimed at reducing barriers to licensure—including successes,
20 failures, and barriers to implementation. (Directive to Take Action)
21
22 4. That Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to US Medical
23 Practice,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal Note: \$1,000.

Appendix A. U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state

IMG's per MAU/P by State



Data sources;

Health Resources & Services Administration (HRSA), Medically Underserved Areas/Populations (MAU/P) data: 2021. Available at: <https://data.hrsa.gov/maps/map-tool/>. Accessed 1-14-21.

Association of American Medical Colleges (AAMC), 2019 State Physician Workforce Data Report. Available at: <https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report>. Accessed 1-12-21.

Map created with Microsoft Power BI.

Appendix B. Visa Options for Non-U.S. Citizen International Medical Graduate Physicians

Visa Option	Purpose	Requirements
J-1 Exchange Visitor program ¹⁻²	Intended to provide a broad range of foreign nationals with educational, employment, and training opportunities in the U.S. Allows International Medical Graduate (IMG) physicians to attend residency and fellowship programs in the U.S. <i>Physicians wishing to stay in the U.S. after completion of training (or applying for a Green Card), must first return to their home country for a period of two years.</i>	Educational Commission for Foreign Medical Graduates (ECFMG) Certification* including: 1. Passage of United States Medical Licensing Examination (USMLE) Steps 1 and 2 examinations or the Visa Qualifying Examination (VQE) prepared by the National Board of Medical Examiners, and administered by the ECFMG to establish medical competence 2. Passage of the ECFMG English language examination 3. Possession of an MD degree** from a foreign medical school listed in the International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research (FAIMER®) A statement of need from the government of the country of the physician's nationality or last legal permanent residence to provide written assurance to the Secretary of Health and Human Services of the need in that country for persons with the skills the physician seeks to acquire and that the physician has filed a written assurance with the government of this country that he/she will return upon completion of the training An agreement or contract from a U.S. accredited medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education (GME), signed by the physician and the official responsible for the training <i>Upon entry to the U.S., an IMG is authorized to pursue GME training for a period of up to seven years. Each year, the training program in conjunction with the IMG must file an extension application with the ECFMG.</i>
J-1 Waiver ³	Can be granted for the J-1 two-year requirement. <i>The most common waiver options are those granted by: 1) obtaining an official recommendation from an interested government agency in need of the physician's services, or 2) through the</i>	Grounds under law to obtain a waiver of home residence obligation: • If the physician will suffer from persecution in his/her home country or country of last permanent residence • If fulfillment of the two-year home residence obligation will subject a U.S.

	<i>Conrad 30 Waiver Program offered by states in exchange for three years of service in a qualifying medically underserved area.</i>	citizen spouse or child to exceptional hardship Based on a recommendation issued by a government agency interested in the physician's continued residence or employment in the U.S.
H-1B Temporary Worker classification ⁴	Enables a foreign national to enter the U.S. to accept professional level employment for a period of up to six years. <i>IMG physicians must have an existing job offer for full-time employment with a U.S. employer. This can be a hospital, university, clinic, a doctor's office, or an assisted living community.</i>	A certified Labor Condition Application covering each location where the physician will perform services as required under Department of Labor regulations Completion of a medical degree from either a U.S. based school or an acceptable school in a foreign country Possession of a full, unrestricted state medical license or the "appropriate authorization" for the position Completion of the USMLE (Steps I, II, and III) or be eligible for the limited exceptions to this requirement English language competence as established through graduation from an accredited medical school or by passing the ECFMG English language examination
O-1 Visa: Individuals with Extraordinary Ability or Achievement ⁵	Option for well-established doctors who are looking to come to the U.S. to practice. <i>Significant amount of documentation needed to qualify</i>	Must demonstrate (through awards, publications, or other evidence) extraordinary accomplishments in the medical field The position for which the physician is going to work must require someone with well-above average skills and experience Abilities must be corroborated with consultation letters (detailed letters of recommendation) from other respected experts in the applicant's specific field May be exempted from the USMLE examination requirement (some state medical boards may still require USMLE passage)

*All IMGs, regardless of country of citizenship, are required to complete ECFMG Certification to be eligible for J-1 visa sponsorship for clinical GME in the U.S. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. U.S. and Canadian citizens who graduate from medical schools located outside the U.S. and Canada are considered IMGs and must be certified by ECFMG.¹

**The [ECFMG Reference Guide for Medical Education Credentials](#) lists the exact name of the final medical diploma that these applicants must have earned (and must provide).

1. Exchange Visitor Sponsorship Program (EVSP). Educational Commission for Foreign Medical Graduates. Available at: <https://www.ecfm.org/evsp/> (Accessed 7-20-20).
2. Exchange Visitor Program. U.S. Department of State. Available at: <https://j1visa.state.gov/programs> (Accessed 7-16-20).
3. Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement. U.S. Department of State-Bureau of Consular Affairs. Available at: <https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html> (Accessed 7-20-20).
4. H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers, and Fashion Models. U.S. Citizenship and Immigration Services. Available at: <https://www.uscis.gov/working-united-states/temporary-workers/h-1b-specialty-occupations-dod-cooperative-research-and-development-project-workers-and-fashion-models> (Accessed 7-16-20).
5. O-1 Visa: Individuals with Extraordinary Ability or Achievement. U.S. Citizenship and Immigration Services. Available at: <https://www.uscis.gov/working-united-states/temporary-workers/o-1-visa-individuals-extraordinary-ability-or-achievement> (Accessed 7-20-20).

Appendix C. Rule Changes/ Proposed Rule Changes

J-1's

- In October 2020, the U.S. Department of Homeland Security (DHS) released a proposed rule titled “[Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media](#).” The proposed administrative change to eliminate “duration of status” as an authorized period of stay would significantly disrupt the medical specialty and subspecialty training of thousands of foreign national physicians in the United States in J-1 visa status, which in turn will have severe implications for patient care.
- DHS is proposing to eliminate the duration of status in favor of only admitting J-1 physicians until the program end date noted in their Form I-20 or DS-2019, not to exceed four years, unless they are subject to a more limited two-year admission, plus a period of 30 days following their program end date. Individuals who need time beyond their period of admission would have to timely file a complete extension of stay (EOS) with U.S. Citizenship and Immigration Services (USCIS) before their prior admission expires. As such, under the proposed rule, J-1 physicians applying for EOS would need to file a Form I-539 with the required fee, provide biometrics, and possibly undergo an interview. While the rule provides an admission period of two to four years, this timeframe will not be applicable to J-1 physicians because they are required to undergo an annual application process.
 - On October 23, 2020, the AMA [commented](#) on a DHS proposed rule concerning “Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media.”
 - The AMA urged DHS to withdraw the proposed rule as it relates to J-1 IMGs.
 - The AMA signed onto two letters, one that was circulated around the [Hill](#) and one that was submitted as a [formal comment](#) that asked that IMGs be exempt from the proposed rule.
 - The AMA spearheaded a [letter](#) that was sent by Representatives Brad Schneider (D-IL), Abby Finkenauer (D-IA), and David McKinley (R-WV) to the Department of Homeland Security (DHS) in opposition to the regulatory changes to duration of status for J-1 physicians. The letter also opposes the regulation because it will disrupt the Conrad 30 Program. The letter was co-signed by 36 bipartisan members of Congress and sent to DHS’ Legislative Affairs Department.

H-1B's

- The AMA drafted a [letter](#) in opposition to the interim final rule “[Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States](#).” In the letter the AMA strongly urged the U.S. Department of Labor (DOL) to rescind the Interim Final Rule (IFR), effective October 8, 2020. If rescission is not possible, we urged the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urged the DOL to continue to approve, and DHS to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.
 - Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of “the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question,” or “the prevailing wage level for the occupational classification in the area of employment.” Without providing evidence-based reasoning, this rule increased wage levels. Specifically,

the entry level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile.

- Recently ruled to be in violation of the Administrative Procedure Act by a District Court.
- Implementation date has been delayed. [Comment period](#) has been reopened until April 21, 2021. Rescindment of rule also under consideration.
- The AMA commented on proposed rule “[Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions.](#)”
 - DHS proposed to amend its regulations governing the process by which U.S. Citizenship and Immigration Services (USCIS) selects H-1B registrations for filing of H-1B cap-subject petitions (or H-1B petitions for any year in which the registration requirement will be suspended), by generally first selecting registrations based on the highest Occupational Employment Statistics (OES) prevailing wage level that the proffered wage equals or exceeds for the relevant Standard Occupational Classification (SOC) code and area(s) of intended employment.
 - On December 2, 2020, the AMA submitted [comments](#) strongly opposing the DHS proposed rule “Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions.” This proposed rule seeks to abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest prevailing wage or highest proffered wage. In our comments, we acknowledge that it is false to assume that higher skilled workers are always paid a higher wage and thus, this conclusion made by DHS devalues physicians practicing in medically underserved areas. AMA strongly urged DHS to withdraw the proposed rule, but if withdrawal is not possible, DHS was urged to exempt physicians from this provision.
 - It was scheduled to go into [effect](#) March 9, 2021 but has been [delayed](#) until December 31, 2021
- The AMA commented on proposed rule “[Strengthening the H-1B Nonimmigrant Visa Classification Program.](#)”
 - DHS is proposing to revise the regulatory definition of and standards for a “specialty occupation.”
 - On December 4, 2020, the AMA [submitted comments](#). The United States District Court of the Northern District of California ruled on December 1, 2020 that the IFR is in violation of the Administrative Procedures Act. For the reasons stated in the court’s ruling, we agree. The AMA strongly urges DHS to rescind the IFR. If this, or a similar rule is implemented in the future, DHS was urged to exempt physicians.

Appendix D: Relevant Policy

D-255.978, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.

(Res. 308, I-19)

H-255.983, Graduates of Non-United States Medical Schools

The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

(Sub. Res. 45, A-88 Reaffirmed by Res. 311, A-96 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 7, A-04 Reaffirmed: Sub. Res. 314, A-04 Reaffirmed: CME Rep. 11, A-10 Reaffirmed: BOT Rep. 25, A-15)

H-275.934, Alternatives to the Federation of State Medical Boards Recommendations on Licensure

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

(CME Rep. 8, A-99 Reaffirmed: CME Rep. 4, I-01 Reaffirmed: CME Rep. 2, A-11 Modified: CME Rep. 2, A-12)

H-255.966, Abolish Discrimination in Licensure of IMGs

Medical Licensure of International Medical Graduates

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
 - A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
 - B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
 - C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
 - D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
 - E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
 2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
 3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
 4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
- (BOT Rep. 25, A-15)

H-255.985, Graduates of Foreign Health Professional Schools

- (1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.
- (BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13)

H-255.988, AMA Principles on International Medical Graduates

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19)

D-275.989, Credentialing Issues

1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.

2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.

(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11)

D-255.991, Visa Complications for IMGs in GME

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
 4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
- (Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19)

D-255.985, Conrad 30 - J-1 Visa Waivers

1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
- (Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12 Appended: BOT Rep. 27, A-13 Reaffirmation A-14)

D-255.980, Impact of Immigration Barriers on the Nation's Health

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19)

H-200.972, Primary Care Physicians in Underserved Areas

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.

(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.

(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.

(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.

(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

(CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19)

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REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Promising Practices Among Pathway Programs to Increase Diversity in Medicine
(Reference Committee C)

EXECUTIVE SUMMARY

In the early 1960s, cross-sectional efforts began to support increased diversification of the medical workforce through “pipeline programs” in response to a projected nationwide shortage of physicians. The shortage of physicians who are underrepresented in medicine (URM) was a consequence of structural factors that contributed to the marginalization of Black, Hispanic/Latinx, and Indigenous people, including exclusion from participation in medical education and careers in medicine. Legislative efforts such as Title VII programs were a means to improve the maldistribution of physicians and other health professionals and to improve the racial and ethnic diversity of the health care workforce. The two Title VII pipeline programs with the largest impact on enrollment of historically underrepresented groups in medicine are the Health Career Opportunity Program (HCOP) and the Centers of Excellence (COE). Over time, the term pipeline evolved to “pathway” to reflect the multiple paths to a career in medicine and to move away from the negative connotation associated with “pipeline.” These pathway programs have provided opportunities to support the increase of racial, ethnic, gender, and socioeconomic diversity of the medical workforce. In addition to these public programs, there are numerous private pathway programs across the continuum of medical education to support diversity in medicine and access to care for the underserved.

Although there is limited evidence on the effectiveness of pathway programs, high quality studies suggest that interventions such as targeted recruitment and revised admissions policies; curriculum changes; summer enrichment programs; and comprehensive programs that integrate multiple interventions, such as financial, academic, and social support, can exert a meaningful, positive effect on student outcomes and increase diversity across various levels of educational settings.

The success of “pathway programs” has been hindered by anti-affirmative action initiatives; inconsistent funding for Title VII programs; disparities in the development of an adequate applicant pool for medical school admissions; disparities in the admissions, recruitment, and retention rates for historically underrepresented groups in medical education and medicine; and negative social integration into the campus, training, and work environment. Efforts to make the medical workforce more reflective of the nation’s diversity will have to address multiple factors along the continuum of the education system and professional development. Additionally, it should be noted that oppressive structures, policies, and culture are perpetuated in various forms today and new pathway programs have emerged to expand gender equity among specific specialties such as radiology, orthopaedic surgery, and obstetrics/gynecology.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-JUN-21

Subject: Promising Practices Among Pathway Programs to Increase Diversity in Medicine

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 AMA Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,”
4 asks that the AMA (a) support the publication of a white paper chronicling health care career
5 pipeline programs (also known as pathway programs) across the nation aimed at increasing the
6 number of programs and promoting leadership development of underrepresented minority health
7 care professionals in medicine and the biomedical sciences, with a focus on assisting such
8 programs by identifying best practices and tracking participant outcomes; and (b) work with
9 various stakeholders, including medical and allied health professional societies, established
10 biomedical science pipeline programs, and other appropriate entities, to establish best practices for
11 the sustainability and success of health care career pipeline programs.
12

13 The Council on Medical Education offers this report to provide an overview of interventions used
14 by “pathway programs” based on targeted milestones along the journey to becoming a physician; to
15 identify institutional and structural factors that interfere with or create attrition on the journey; and
16 to discuss recommendations to minimize interference/attrition on the journey to becoming a
17 physician.
18

19 DEFINITION OF PIPELINE/PATHWAY PROGRAMS IN MEDICINE

20
21 Historically, the term “pipeline” in medical education has been used as a metaphor to describe the
22 progression of individuals from one level of medical education to the next.¹ However, it should be
23 noted that use of this term has been criticized as the model erroneously presents a series of
24 invariant steps necessary to pursue a career in medicine. This rigid and reductionist approach can
25 have an especially negative impact on women and underrepresented groups in their pursuit of
26 medical careers.² More recently the adoption of the term “pathway” has gained favor as it
27 symbolizes a more flexible and less restrictive course that individuals can take on their path to
28 becoming physicians. For the purposes of this report, the term “pathway programs” will be used to
29 describe the progression of individuals from one level of medical education to the next. The
30 pathway therefore begins as early as prekindergarten and extends through college, medical school,
31 graduate medical education (GME), and up to faculty development. Pathway programs are
32 designed to assist individuals, particularly those who have been historically underrepresented in
33 medicine (URM), to envision a career in medicine and successfully transition from any one stage
34 of education to the next with the goal of bolstering care for historically marginalized and
35 minoritized patients. Some of the ways that pathway programs support learners include providing
36 supplemental academic enrichment programs, experiential learning in medical/clinical settings,
37 research experience, career/college counseling, standardized exam preparation, and mentorship.

Given that health inequities are identified in all areas, URM individuals can be expected to enhance outcomes in any clinical discipline and deserve the opportunity for a rewarding career in medicine. The rationale for encouraging the creation of programs to enhance medical student diversity is that racial and ethnic diversity among health professionals has been shown to promote better access to health care, improve health care quality for underserved populations, and better meet the health care needs of an increasingly diverse population.³ While it is a duty of all physicians to aid serving the underserved and support primary care, URM physicians have been found to be more likely to work in underserved areas and thereby increase access to health care for historically marginalized and minoritized patients. Additionally, diverse learners add value to medical education and research environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.^{4,5}

HISTORY OF THE CREATION OF PATHWAY PROGRAMS IN THE UNITED STATES

For the first two-thirds of the twentieth century, U.S. medical schools were de facto segregated, since few medical schools would admit Black students. In 1900, Black students who aspired to have a career in medicine could only choose from 10 schools in the U.S.⁶ Following the establishment of the Council on Medical Education in 1904, the Council adopted an “ideal standard” that medical schools ought to require preliminary education sufficient to enable the candidate to enter a recognized university; a five-year medical course; and a sixth year as an intern in the hospital. In 1906, the Council was tasked with rating medical schools and surveyed 160 schools regarding performance of graduates on state licensure examinations. The schools were graded as “acceptable,” “doubtful,” or “nonacceptable” based on a set of 10 defined qualifications. Only 82 schools receive an “acceptable” rating. The Council partnered with the Carnegie Foundation in 1909 to conduct a follow up study, entitled “Medical Education in the United States and Canada, a Report to the Carnegie Foundation for the Advancement of Teaching,” which was known as the Flexner Report of 1910.

The Flexner Report of 1910, which shaped medical education in the subsequent century, alleged support of medical education at the historically Black colleges and universities to provide a physician workforce that would serve Black Americans, yet its recommendations resulted in the closure of 89 medical schools, including five of the remaining seven medical schools that trained Black physicians, due to these schools’ inability to meet the standards set at the time.⁷ The report also went beyond describing the substandard conditions at medical schools; it prescribed a limited role for Black physicians in their practices and hinted that Black physicians possessed less potential and ability than their white counterparts. Among his other findings, Flexner concluded that “educating the [Black] race to know and to practice fundamental hygienic principles” fell naturally to the Black doctor. Thus, “a well-taught negro sanitarian will be immensely useful.” Flexner not only limited the role of African American physicians to caring for other African Americans but further restricted Black doctors to matters of public health.⁸ While he viewed both Meharry Medical College and Howard University as being suitable for training Black physicians, he recommended divestment from the five underperforming institutions serving Black medical students and reallocation of those resources to Meharry Medical College in Nashville, Tennessee, and Howard University Medical Department in Washington, DC.

As recently as 1964, 93 percent of all medical students in the United States were men and 97 percent of those students were non-Hispanic white. Of the remaining three percent of medical students, all but a few were enrolled in Howard University and Meharry Medical College. At that time, less than 0.2 percent of all medical students were Mexican American, Puerto Rican, American Indian, or Alaska Native. Prevailing societal values and practices within the profession were reflected in restricted opportunities for URM medical school graduates to participate in

1 specialty training, medical society membership, hospital staff membership, and other professional
2 activities.⁷

3
4 Beginning in the early 1960s, cross-sectional efforts began to support increased diversification of
5 the medical workforce. In 1963, Congress passed the Health Professions Educational Assistance
6 Act (P.L. 88-129, amending the Public Health Service Act or PHSA) in response to a projected
7 nationwide shortage of physicians. The act was the first comprehensive legislation to address the
8 supply of health care providers and initially authorized grants for the construction of new teaching
9 facilities and loans to support students in the study of medicine, dentistry, and osteopathic
10 medicine. The emphasis of Title VII programs shifted through several reauthorizations in the 1970s
11 and 1980s. Title VII programs were seen as a means to improve the maldistribution of physicians
12 and other health professionals. Programs were authorized to increase the numbers of health
13 professionals in underserved (mostly rural or inner-city) areas and to improve the racial and ethnic
14 diversity of the health workforce by increasing the numbers of those who had been historically
15 excluded from careers in medicine. In addition, programs were developed to counter the
16 nationwide trend of medical specialization. The major objective of these programs was to increase
17 support for training and curriculum development in primary care.⁹ Title VII programs are
18 administered by the Bureau of Health Professions at the Health Resources and Services
19 Administration (HRSA) in the Department of Health and Human Services (HHS).

20
21 The adoption of pathway programs by the Association of American Medical Colleges (AAMC) as
22 a strategic way to increase the number of URM physicians also emerged from the civil rights
23 activism of the 1960s. Nickens et al. explain that “actions to promote diversity in medical schools
24 reflected the heightened sensitivity to racial injustice spurred by the civil rights movement.”¹⁰ In
25 1964, only 2.2 percent of the total 32,000 medical students enrolled nationwide were Black, and the
26 two historically Black colleges and universities (HBCUs) enrolled 76 percent of these students. On
27 average all other medical schools enrolled a single Black student every two years.⁸ At the 1968
28 AAMC annual meeting, medical students, faculty, and administrators asked for the creation of a
29 task force and strategies to increase enrollment among URM students. The underrepresentation of
30 these groups was found to be so great that the task force placed highest priority on increasing the
31 number of URM medical students from 2.8 percent to 12 percent within five years.⁹ The other
32 recommendations centered around retention of students on the medical career pathway, providing
33 financial assistance, and recruitment of students into the medical pathway.⁹ At the same time, there
34 was widespread implementation of new “academic-enrichment programs” for premedical and post-
35 baccalaureate students.⁸ These enrichment programs as well as a rise in Black college student
36 enrollment and the use of affirmative action in medical school admission led to a rapid increase in
37 medical student enrollment among URM students from 3 percent in 1968 to 10 percent by 1974.¹¹
38 Data on the enrollment of non-Black minoritized individuals was not collected until 1971.

39
40 Although these programs remained in place from 1974-1990, the general population rate of
41 minoritized communities increased faster than medical school enrollment among those who had
42 been historically excluded from medicine, so there was greater underrepresentation of these groups
43 in medical schools in 1990 than in 1975. By 1990, the general minoritized population was 20
44 percent while URM medical students represented 9 percent of all medical students. In 1990, the
45 AAMC launched the *3000 by 2000* initiative, which aimed to enroll 3000 URM medical students
46 annually by the year 2000. As part of this initiative, the AAMC adopted the “pipeline” metaphor
47 that had been previously used in the science and engineering fields.¹⁰ The first major aspect of this
48 initiative encouraged medical schools to partner with local magnet high schools to provide
49 minoritized students early exposure to the health professions and to academically prepare students
50 to undertake rigorous pre-medical or pre-health professional coursework in college. The second
51 aspect of the initiative included forming more articulated agreements between undergraduate

institutions and medical schools to encourage the enrollment and advancement of URM students into and through medical school. Last, the initiative encouraged science-education partnerships between academic health education centers (AHECs) and local primary school systems wherein AHEC faculty helped design scientific curricula that encouraged critical thinking and problem solving rather than simple memorization in the public school system. Although the *3000 by 2000* initiative did not achieve its enrollment goal, partially due to national resistance against affirmative action at the time, it paved the way for widespread pathway partnerships between medical schools, undergraduate institutions, and primary schools, many of which remain to this day.¹⁰

In 2009, the Liaison Committee on Medical Education (LCME), which accredits medical education school programs in the United States and Canada, revised its diversity standards to require that all U.S. allopathic medical schools engage in systemic efforts to attract and retain students from diverse backgrounds. The diversity standards were defined by the medical schools and the standards did not set numerical goals, but sought to ensure that all medical schools had a “mission-appropriate” diversity policy.¹² Evaluation of these medical school programs, some of which are pathway programs, has demonstrated modest enrollment increases in the proportions of URM medical students.⁴ According to data collected for the 2019-2020 academic year, 149 (97 percent) of LCME-accredited medical schools have or support at least one pathway program to prepare participants (from the school’s diversity categories) for potential admission to medical school. Table 1 summarizes the types of “pipeline programs” in U.S. MD-granting medical schools.

Table 1 Types of Pipelines Programs in U.S. MD-Granting Medical Schools, 2019-2020

Type of Pipeline Program ^a	No. (%) of Medical Schools ^b
Pre-college-level only	6 (4.0)
College-level only	13 (8.7)
Postbaccalaureate only	1 (0.7)
Pre-college and college-levels	59 (39.6)
Pre-college, college, and postbaccalaureate levels	54 (36.2)
College and postbaccalaureate levels	12 (8.1)
Pre-college and postbaccalaureate levels	4 (2.7)

Source: LCME, 2020

^aPre-college level includes programs at the middle school and/or high school levels

College level includes programs at the college/university level and/or BA/MD programs/guaranteed medical school admission programs

Postbaccalaureate programs include programs for college graduates to complete additional course requirements or other pre-medical requirements

^b149 medical schools reported having one or more pipeline programs: middle school (69 schools), high school (122 schools), college/university (123 schools), BA/MD or guaranteed admission programs (49 schools), postbaccalaureate programs (71 schools)

Table 2 summarizes the number of new medical students matriculating into a U.S. MD- or DO-granting medical school who came from at least one of a school’s supported pathway programs.

Table 2 New Medical Students Who Came from a Pathway Program in 2019-2020

Type of Program	# Matriculating to Respondent's Medical School	# Matriculating to Another U.S. MD/DO Granting Medical School
Middle school program only	7	0
High school program only	158	55
College program only	872	580
BA/MD/guaranteed-admission program only	921	47
Postbaccalaureate program only	907	637
More than one type of the school's pipeline program	210	39

Source: LCME, 2020

However, although absolute numbers of Black and Hispanic/Latinx matriculants have increased since 2009, representation of these groups in medicine as a proportion of the general population has not increased.⁵ Additionally, Lett et al. found “no statistically significant trend towards increased representation of Black and Hispanic/Latinx male individuals and a modest trend towards increased representation for Hispanic/Latinx female applicants.” In fact, they found “that Hispanic/Latinx individuals are underrepresented among medical school applicants and matriculants by nearly 70% relative to the age-adjusted U.S. population; Black male applicants and matriculants, nearly 60%; Black female applicants, nearly 30%; and Black female matriculants, nearly 40%.” Additionally, Lett et al demonstrated that the representation of minoritized faculty relative to the general population has actually decreased in almost all specialties and across all faculty rankings since 2009.¹³

EVOLUTION FROM “PIPELINE” TO “PATHWAY” PROGRAM

It is important to consider the implications of using specific terminology about programs focused on increasing diversity in medicine. The term “pathway program” is gaining favor as it suggests a more open and flexible path to becoming a physician; the term “pipeline program,” however, is still prevalent both in the literature and in everyday conversations. Some believe the metaphor of the “pipeline” is misleading and inaccurate. The pipeline metaphor suggests there is a single path to becoming a doctor with a single entry and exit point.¹⁴ Many URM medical students follow a non-traditional path to medical school, such as participating in post-baccalaureate programs to strengthen their academic profile, so the idea of a rigid pipeline that requires early access and success in science and medicine may be particularly discouraging to minoritized students.¹³ Giordani et al. demonstrated that non-traditional students with lower Medical College Admission Test (MCAT) scores and undergraduate GPAs who pursue post-baccalaureate programs are just as likely as their traditional peers to succeed once they enter medical school.¹⁵ Another reason some criticize the term “pipeline” is its allusion to the “school-to-prison pipeline,” a phenomenon known to disproportionately impact minoritized youth.¹⁶ While the criminalization of minoritized children in schools is a worthwhile concern to address in pathway programs—minoritized students cannot be guided toward academic success when trapped in a “pipeline” of isolation, punishment, aggressive school policing, and inadequate academic preparation due to lack of resources—echoing the same terminology for a program promoting equity is inappropriate. Additionally, the word “pipeline” has negative connotations in Native American communities that are a prioritized group for recruitment. “Pipelines” within Indigenous communities are often literal, calling to mind current struggles with oil industries against environmental degradation, threats to communities’ health and safety, and continued colonization. Alternatively, the term “pathway” implies learners’ agency and offers more than a single path to medicine, which can include non-traditional students,

individuals who change careers later in life, and those who did not have early exposure to medicine.¹³

CURRENT FEDERAL PATHWAY PROGRAMS

The Title VII health professions and Title VIII nursing workforce development programs, which are authorized under the Public Health Service Act and administered by the HRSA, increase the supply, distribution, and diversity of the health care workforce, reaching over 400,000 participants.¹⁷ These programs improve access to, and quality of care for, vulnerable populations, including children and families living on low incomes and in rural and underserved communities. In addition, as ever-changing public health threats such as the COVID-19 pandemic and substance use disorder epidemics, impact patients across the country, continued investment in Title VII programs is essential to addressing the health challenges of today and the future.

Title VII programs play an essential role in improving the diversity of the health care workforce and connecting students to health careers by supporting recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences expose physicians and other health care professionals to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients. The Title VII programs include:

- *Centers of Excellence*: Provides grants for mentorship and training programs. In academic year 2018-19, this program supported over 1,300 trainees, of whom 99% were underrepresented minorities and 64% were from financially or educationally disadvantaged backgrounds.
- *Health Career Opportunity Program*: Invests in K-16 health outreach and education programs through partnerships between health professions, schools, and local community-based organizations. In academic year 2018-19, over 4,000 students from rural and disadvantaged backgrounds were exposed to the health professions pathway.
- *Primary Care Training and Enhancement (PCTE)*: Supports training programs for physicians and physician assistants to encourage practice in primary care, promote leadership in health care transformation, and enhance teaching in community-based settings. In academic year 2018-19, PCTE grantees trained over 13,000 individuals at nearly 1,000 sites, with 61% in medically underserved communities and 30% in rural areas.
- *Medical Student Education*: Supports the primary care workforce by expanding training for medical students to become primary care clinicians, targeting institutions of higher education in states with the highest primary care workforce shortages. The grants develop partnerships between institutions, federally recognized tribes, and community-based organizations to train medical students to provide care that improves health outcomes for those living on tribal reservations or in rural and underserved communities.
- *Area Health Education Centers (AHECs)*: Responds to local health needs and serves as a crucial link between academic training programs and community-based outreach programs. In academic year 2018-19, AHECs supported 192,000 pathway program participants, provided over 34,000 clinical training rotations for health professions trainees, and placed over 92,000 trainees in rural and underserved training sites.

- *Mental and Behavioral Health:* Funds training programs to expand access to mental and behavioral health services for vulnerable and underserved populations. In academic year 2018-19, the Graduate Psychology Education program partnered with 184 sites to provide clinical training experiences for psychology students. Of these sites, 48% offered substance use disorder treatment services, and 38% offered telehealth services.

HRSA also administers the Minority Faculty Fellowships Program, with the goal of increasing the number of minoritized faculty at awardee institutions. The program awards 50 percent of faculty salary, with the institution matching funds. Fellows are prepared to assume tenured faculty positions at the institution and to provide services in underserved areas.⁸

Additionally, and as previously reported in Council on Medical Education Report 5-A-18, “Study of Declining Native American Medical Student Enrollment,” the Indian Health Service (IHS) supports American Indian/Alaska Native (AI/AN) entry into the health professions and provides opportunities to explore career paths in AI/AN health care. The IHS Scholarship program has awarded more than 7,000 health professions scholarships since 1978. The IHS website provides links to allow potential students to arrange IHS externships (with salary) and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of \$20,000 per year of commitment (maximum \$40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to \$50,000 for a two-year commitment.¹⁸

CURRENT UNDERGRADUATE PATHWAY PROGRAMS

The CUNY School of Medicine (formerly Sophie Davis Biomedical Education Program), located in Harlem, recruits and educates a diverse, talented pool of students to its MD and physician assistant programs, expanding access to medical education to URM individuals from underserved communities of limited financial resources. The BS/MD degree program admits students directly from high school into an undergraduate biomedical program with a seamless transition into the medical school curriculum based on a seven-year curriculum. The program has graduated over 2,000 alumni who have become physicians, many of whom practice in underserved communities.

The Summer Health Professions Education Program (SHPEP) was initially established following a study by the Robert Wood Johnson Foundation (RWJF) in 1984 to identify strategies to reverse trends dating back to 1977 of declining URM medical school applicants. The program was originally known as the Minority Medical Education Program (MMEP), which was intended to increase the acceptance rates among medical school applicants who were African Americans, Mexican Americans, mainland Puerto Ricans, and AI/AN, as these groups have historically been underrepresented in medicine due to structural racism. Over the years, MMEP’s intensive academic preparation program expanded to 11 medical school campuses and the AAMC assumed the role of National Program Office in 1993. The program changed its name in 2003 to the Summer Medical Education Program (SMEP) to reflect the inclusion of students representing a range of economic, cultural, and geographic diversity. The program continued to evolve in 2006 when it expanded to include dentistry and was renamed the Summer Medical and Dental Education Program (SMDEP). SMDEP focused on students in the first two years of their college education because the experience of previous programs indicated that this is when students derive the most benefit. Most recently, the program expanded again in 2016 to include a range of health professions due to the growing importance of team-based care and interprofessional collaboration, leading to the most recent change in the program name, to SHPEP.¹⁹ As of 2020, the program has served 27,164 participants at 12 universities across the U.S.

Doctors Back to School (DBTS) was launched by the AMA Minority Affairs Consortium (now called the Minority Affairs Section) in 2002. The DBTS program encourages Black, Indigenous, and Hispanic/Latinx students to enter the health care pathway through conversations with these children in a classroom setting. DBTS has developed a Doctors Back to School™ Kit to support physicians and medical students who act as role models by visiting elementary and high schools to talk with marginalized students about careers in medicine. The program demonstrates to marginalized students that a medical career is well within their reach. In 2016, the program declared the second Wednesday in May as National Doctors Back to School™ Day.

The American Academy of Ophthalmology and the Association of University Professors of Ophthalmology partnered to provide first- and second-year URM medical students one-on-one mentorship, valuable guidance in medical career planning, networking opportunities, and access to a variety of educational resources through their Minority Ophthalmology Mentoring (MOM) program. The MOM Class of 2020 provided opportunities for 50 students. Additionally, the National Medical Association developed the Rabb-Venable Excellence in Ophthalmology Research Program to help increase exposure to ophthalmology as a potential specialty choice among URM students and residents/fellows.

In addition to these national programs, there are numerous programs in the U.S. to boost diversity across the medical continuum. Mentoring in Medicine (MIM) prepares marginalized students in 3rd grade to become biomedical professionals by enabling them to interact with, and learn from, experienced health care professionals and scientists from health professional schools around the U.S. MIM offers an array of age-appropriate programs that involve reaching out to students on a regular basis, creating supportive social circles, providing academic enrichment, exposing students to hospital and research environments, coaching them on leadership and life skills, and providing prospective medical students with exposure to a supportive, but rigorous boot camp. Tour for Diversity (T4D) educates, inspires, and cultivates the future generation of URM physicians, dentists, and pharmacists by conducting national tours in February and September to provide comprehensive workshops to high school and college students that focus on motivating them toward a strong career path, building critical skills, optimizing the application process, and developing mentoring relationships. T4D also provides students with virtual opportunities via hosted webinars that are both interactive and recorded. Building the Next Generation of Academic Physicians (BNGAP) was established in 2008 to address the lack of URM individuals serving as faculty at academic health centers and works to promote diversity and inclusion in the academic medicine workforce.

There are also programs that focus on the development of the health care workforce to increase access to care for underserved people such as those in rural communities. Successfully Training and Educating Pre-medical Students (STEPS) aims to increase the number of primary care physicians in northeast Kentucky by providing opportunities such as physician shadowing, mock interviews, and MCAT practice exams for pre-medical students in the Appalachian region. Frontier Area Rural Mental Health Camp and Mentorship Program (FARM CAMP) strives to reduce the shortage of behavioral health professionals in rural Nebraska. FARM CAMP offers a week-long camp to teach high school students in rural and tribal communities about different career options in behavioral health and provides mentorship after the camp ends. Frontier and Rural Workforce Development New Mexico (FORWARD NM) Pathways to Health Careers was established to address the chronic shortages of primary care physicians and other health care professionals in New Mexico's southwestern counties of Hidalgo, Catron, Luna, and Grant; additionally, New Mexico has the oldest physician population in the country. This comprehensive workforce pathway program includes programming for middle and high school students, undergraduate and graduate students, primary care program students, and medical and dental residents.²⁰

1 Additionally, in 2010, Columbia University College of Physicians and Surgeons and Bassett
2 Medical Center joined forces to launch a new model of medical training to address the severe
3 shortage of rural physicians and train a new generation of doctors capable of leading health systems
4 that promote both quality of practice and cost-effective delivery of care. Students begin their
5 training for 18 months in Manhattan and then head to Cooperstown, N.Y., for two and a half years
6 to obtain clinical training. Students experience both an urban health care setting and a rural health
7 care environment, while being exposed to features not typically part of the medical school
8 curriculum, such as finance, risk management, patient safety, quality improvement, and medical
9 informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of
10 \$30,000 per year for all four years.

11
12 To help highlight the needs of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ)
13 community, in 2020 the American Medical Association Foundation (AMAF) established its
14 LGBTQ Fellowship Program to influence the future of LGBTQ health. The new initiative will
15 create a cadre of LGBTQ health specialists through a national fellowship program to promote best
16 practices and shared outcomes, while improving the quality of LGBTQ health care across the
17 nation. The program was created to address the intersectional issues of discrimination, stigma, and
18 limited access to and lower quality of care experienced by lesbian, gay, bisexual, and transgender
19 individuals. A primary goal of the program is to create a pathway for LGBTQ health specialists
20 who are able to serve the health care needs of the LGBTQ community while growing the pool of
21 competent instructors able to “pay it forward” by passing on their knowledge to the next generation
22 of LGBTQ physicians.

23 24 CURRENT GRADUATE MEDICAL EDUCATION PATHWAY PROGRAMS

25
26 There are also initiatives to increase diversity in competitive specialties such as orthopaedic
27 surgery and radiology, as well as expand gender equity in the specialties of family medicine and
28 obstetrics and gynecology. Nth Dimensions was founded in 2004 by orthopaedic surgeons working
29 collaboratively with academic institutions, community surgeons, and industry to address the dearth
30 of women and other URM groups in orthopaedic surgery. Nth Dimensions offers an eight-week
31 clinical and research internship with a practicing researcher, which also includes a full-day
32 orientation and culminates in the student presenting a research poster at the annual National
33 Medical Association assembly. Following successful completion of the summer internship
34 program, students receive scholarships to participate in a designated Step 1 board review course,
35 which is conducted throughout their second year in medical school. Nth Dimension also offers
36 clinical correlations lectures and hands-on workshops to increase awareness of the specialty being
37 addressed through surgeon-led lectures and hands-on workshops with target groups of URM
38 groups and women. The American College of Radiology established the Pipeline Initiative for the
39 Enrichment of Radiology (PIER) internship program for first-year medical students at institutions
40 across the U.S. in hopes of giving women and other URM groups an opportunity to explore the
41 radiology specialty and engage in research. The internship begins in June and culminates with
42 presentation of the students’ research to the radiology section of the National Medical Association.
43 Additionally, the AMA Reimagining Residency initiative is currently sponsoring two innovative
44 pathway programs. California Oregon Medical Partnership to Address Disparities in Rural
45 Education and Health (COMPADRE) is a collaboration between Oregon Health & Science
46 University and University of California, Davis, 10 health care systems, 10 institutional sponsors,
47 and a network of federally qualified health centers that aims to jointly address workforce shortages
48 in rural, tribal, urban, and other disadvantaged communities between Sacramento and Portland. The
49 University of North Carolina has developed Fully Integrated Readiness for Service Training
50 (FIRST): Enhancing the Continuum from Medical School to Residency to Practice, which expands
51 the geographic and specialty reach of the University of North Carolina School of Medicine’s

established residency readiness program. Its additional aims include developing and implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum.

INSTITUTIONAL AND STRUCTURAL FACTORS THAT INTERFERE WITH PATHWAY PROGRAM SUCCESS

Although many students who indicate an early interest in medicine do not progress from one phase to the next, the attrition rate of URM medical students is even higher than those of their non-minoritized counterparts.^{1,21} This disproportionate attrition rate is multifactorial and occurs in all phases of the pathway. Some factors that disproportionately affect URM students include attending lower performing high schools and colleges, financial barriers to higher education, lower levels of academic attainment among parents of minoritized students (which has been found to link to a child's outcomes such as academic achievement), and experiences of racism and implicit bias that deter students from continuing with their trajectory.^{4,10} A 2019 study published in *JAMA* found that while the U.S. population of male and female 24- to 30-year-olds, who are Black, Hispanic/Latinx, and Native Hawaiian or Pacific Islander (NHOPI) increased between 2002 and 2017, there were no significant increases in medical school applicants and attendees from these groups over the same period. The study also found that from 2002 to 2012, the proportion of Black, Hispanic/Latinx, NHOPI, and AI/AN medical school matriculants remained relatively unchanged and Black, Hispanic/Latinx, and AI/AN students remain underrepresented among medical school matriculants compared with the U.S. population.⁵ Another study the same year found that as medical school enrollment doubled over the past two decades, the percentage of entering underrepresented students actually fell by 16%.²² There are several possible factors that may explain why these groups are still underrepresented in medicine.

While affirmative action efforts helped initially increase enrollment among URM medical students, these initiatives have been met with resistance. In 1974, a reverse discrimination lawsuit brought by Allan Bakke against the University of California (UC) transformed how colleges think about race and equality in admissions. Bakke was a white man who had twice been denied admission to the medical school at UC Davis during the time when positions in the entering class were “reserved” for qualified minoritized students. The case was ultimately heard by the U.S. Supreme Court. Justice Lewis Powell, in the deciding opinion in the case, wrote “the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin” and concluded that “you could use race as a factor in admissions, but that you could not use quotas” (Powell L. 1978. Bakke, 438 US at 312–13 n.48). The Court's decision in *Regents of the University of California v. Bakke* changed the definition of the Equal Protection Clause and inadvertently changed how colleges approached recruiting and enrolling URM in medicine. According to law professor Kevin Brown at Indiana University, the Equal Protection Clause is a short but critical line in the Fourteenth Amendment that states that Americans in similar circumstances should be treated equally under the law. This clause historically aimed to help “discrete and insular minoritized groups.”²³ The decision upended that view. Bakke was admitted to medical school at UC Davis and the school transitioned to a panel of markers that they term “distance traveled,” which is not race-based but serves to support marginalized people based on non-race indicators of socioeconomic disadvantage. However, the Court's decision affirmed the use of race as one among many factors that could be considered as part of the medical school admissions process.¹⁰ The Court's decision provided the window to weaken the practice of race-based affirmative action and as a result enrollment among minoritized groups stagnated.

1 There were additional anti-affirmative action initiatives to follow that negatively impacted efforts
 2 to increase diversity in medicine. Most notable was *Hopwood v. University of Texas* in 1996, in
 3 which the United States Court of Appeals for the Fifth Circuit held that “any consideration of race
 4 or ethnicity by the law school for the purpose of achieving a diverse student body is not a
 5 compelling interest under the Fourteenth Amendment.”²⁴ This decision prohibited public
 6 universities under its jurisdiction (in Texas, Mississippi, and Louisiana) from taking race into
 7 account in their admissions policies. The same year, Proposition 209 was passed in California with
 8 nearly 55 percent of the vote, banning consideration of race and gender in admissions in the state’s
 9 public universities. In 2008, the University of California (UC) “clarified” their policy in
 10 recognition that Native Americans enrolled in a federally recognized tribe enjoy a political status
 11 that enables them to be offered affirmative action, even when the consideration of race or ethnicity
 12 is banned. This policy shift led to a statistically significant surge in the Native American applicant
 13 share, acceptance rate, admit share, and enrollment share. Enrollment share increased by 56% from
 14 2008 to 2010 at the UC.²⁵ In November 2020, nearly 25 years later, voters in California had the
 15 opportunity to repeal Proposition 209 through the work of Assemblywoman Shirley Weber (D-San
 16 Diego), chairwoman of the Legislative Black Caucus and principal author of the proposed
 17 constitutional amendment.²⁶ This effort was unsuccessful, and the amendment was not approved by
 18 voters. Presently, Arizona, Georgia, Michigan, Nebraska, New Hampshire, Oklahoma, and Idaho
 19 have banned affirmative action. A study of 19 public universities in six of these states (Arizona,
 20 Georgia, Michigan, Nebraska, New Hampshire, and Oklahoma) found that the elimination of
 21 affirmative action has led to persistent declines in the share of URM medical students among
 22 students admitted to and enrolling in flagship public universities in these states.²⁷

23
 24 In June 2003, the US Supreme Court ruled on two separate but parallel admissions cases, *Grutter v.*
 25 *Bollinger* and *Gratz v. Bollinger*, involving the University of Michigan and the constitutionality of
 26 using race-conscious decisions as part of its admissions process. Although neither case directly
 27 involved the medical school or other health profession admissions, the Court’s ruling was widely
 28 recognized as one that would have profound bearing on the future of affirmative action in public
 29 higher education nationwide. With these rulings, the Supreme Court recognized the value of
 30 diversity in higher education and preserved the ability to consider race as a factor in admissions
 31 decisions.¹⁰

32
 33 Aside from the impact of court rulings on affirmative action, support for Title VII programs has
 34 been inconsistent over the last decade. In 2005, the Office of Management and Budget (OMB)
 35 published its review of the health professions training programs under Title VII. After years of
 36 effective ratings for Title VII programs, the OMB concluded that these programs were ineffective.
 37 As a result, the HRSA administrator, Elizabeth Duke, informed COE and HCOP grantees that the
 38 administration would no longer support their programs, and in 2006, the federal government cut its
 39 funding abruptly and drastically reduced the number of Centers of Excellence and Health Careers
 40 Opportunity Programs. In February 2006, the Government Accountability Office (GAO) issued a
 41 report entitled *Health Professions Education Programs: Action Still Needed To Measure Impact*,
 42 which reviewed HRSA’s evaluation of the Title VII and VIII (nursing) programs against its overall
 43 performance goals and found that these goals did not apply to all of the health professions
 44 programs and that HRSA’s tracking data was problematic.²⁸ HRSA was criticized for failing to
 45 publish national supply, demand, and distribution projections for the physician and dentist
 46 workforces.

47
 48 In July 2020, the House Appropriations Committee released their Committee Report accompanying
 49 the Labor-HHS-Education FY 2021 allocations, which would provide Title VII Health Professions
 50 and Title VIII Nursing Workforce Development Programs with a total of \$782.5 million, a \$48
 51 million increase (6.5%) from FY 2020 enacted levels.²⁹ In December 2020, the Consolidated

1 Appropriations Act of 2021 passed which includes \$50,000,000 for grants to public institutions of
2 higher education to expand or support graduate education for physicians provided by such
3 institutions. Priority will be given to public institutions located in states with a projected primary
4 care physician shortage in 2025 and are limited to public institutions in states in the top quintile of
5 states with a projected primary care physician shortage in 2025.³⁰

6
7 Historically, disparities in medical school admissions have encompassed more than racial and
8 ethnic gaps. One root cause for this disparity is a lack of resources to support the development of
9 education necessary to be an adequate applicant for medical school admission. While overall
10 educational attainment is increasing, college completion rates and attainment patterns differ
11 considerably across demographic groups. Household income and education levels are tightly
12 linked. Consequently, lower levels of education are correlated with lower household income as
13 well.³¹ This has direct implications for the economic diversity of applicants to medical school.
14 According to a 2018 study conducted by AAMC, roughly three quarters of medical school
15 matriculants come from the top two household-income quintiles, and this distribution has not
16 changed in three decades. Black and Hispanic/Latinx medical students are three times as likely as
17 their white counterparts to come from families with combined parental incomes of less than
18 \$50,000. Black and Hispanic/Latinx students are also much more likely than white students to have
19 attended high poverty primary and secondary schools which strongly affects educational
20 achievement and often leaves these individuals less competitive on traditional academic measures
21 such as MCAT scores and grade-point averages.

22
23 The lower admission rate for URM groups is another challenge to diversification of the medical
24 workforce due to bias. Community college attendance is often viewed negatively by medical
25 schools in the admissions process, despite being a critical educational pathway for many URM
26 students.³¹ To counter this bias, there is a growing trend of holistic review as an admissions
27 strategy to assess an applicant's unique experiences alongside traditional measures of academic
28 achievement such as grades and test scores. It is designed to help admission committees consider a
29 broad range of factors reflecting the applicant's academic readiness, contribution to the incoming
30 class, and potential for success, both in school and later as a professional. Holistic review, when
31 used in combination with a variety of other mission-based practices, constitutes a "holistic
32 admission" process. A key element is that this review concomitantly reduces historical singular
33 focus on metrics that are flawed from the perspective of equity for URM medical students,
34 specifically standardized testing and GPA or the "caliber" of college attended. A holistic admission
35 process is necessary at the collegiate level to increase the pool for subsequent undergraduate
36 medical education, GME, and faculty recruitments. In 2003, the U.S. Supreme Court officially
37 described the strategy as a "highly individualized, holistic review of each applicant's file, giving
38 serious consideration to all the ways an applicant might contribute to a diverse educational
39 environment" (*Grutter v. Bollinger*, 539 US 306, 2003). The AAMC has promoted holistic review
40 in the admissions process to broadly assess how a candidate might contribute value as a medical
41 student and physician. Although practices vary widely, a national survey of health professional
42 schools showed that institutions incorporating "many elements of holistic review" reported
43 increases in class diversity as compared with institutions incorporating few or no elements.³²

44
45 Diversity in the ranks of faculty and administration of medical schools is central to creating a
46 welcoming environment for all students.³¹ However, a study to evaluate trends in racial, ethnic, and
47 gender representation at U.S. medical schools across 16 specialties from 1990–2016 found that the
48 gap between the URM population in the academic physician workforce widened over time for
49 nearly all specialties and faculty rankings.³³ This is problematic, as URM faculty often serve as
50 important role models and mentors for URM medical students and trainees who may struggle with
51 systemic racism in their schools and training environments.³⁴ URM faculty can also promote

1 academic excellence and enhance training across all domains to improve outcomes for all students
2 related to cultural humility, humanism, empathy, and professionalism. “Most institutions recognize
3 the value of multi-cultural outreach and engagement, but often fail in reconciling the associated
4 implications for organizational decision-making. In other words, institutional leaders recognize the
5 benefits of recruiting URM groups into medicine and gaining ideas from diverse sources but lack
6 the understanding or will to ensure that they are integrated into an environment of respect,
7 inclusion and meaningful engagement.”³⁴

8
9 Lastly, negative social integration into the campus environment impacts retention among
10 minoritized and marginalized groups. Tinto’s theory of student departure claims that a student’s
11 individual characteristics (including personal attributes, family background, and high school
12 experiences) directly influence the student’s commitments to an institution, the goal of graduation,
13 and, ultimately, the departure decision.³⁵ Braxton et al. revised the model in 2004 by placing social
14 integration as the pivotal factor in retention and claiming that student characteristics (e.g., gender,
15 race/ethnicity, socioeconomic status, academic ability, high school preparation, and self-efficacy)
16 shape initial commitments to attaining a degree and to the institution.³⁶ Significant factors for
17 minoritized and marginalized student retention include racial climate, presence of an ethnic
18 community, community orientation, campus involvement, acclimation to the academic culture,
19 social connectedness, and the role of religion.³⁷ These factors may be interconnected as having the
20 presence of a similar ethnic community may increase a student’s feelings of support in the event of
21 a racially insensitive incident. Some recent examples of these type of incidents include white
22 students posting photographs of themselves in blackface and disseminating the photos via social
23 media, along with graffiti with swastikas and other “hateful language” in dormitories and on
24 campus buildings; however, incidents do not have to be blatant to be harmful.³⁸ Microaggressions
25 which are brief yet common verbal, behavioral, or environmental indignities, whether intentional or
26 unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward
27 people of color can also negatively impact one’s experience in the classroom, training environment
28 and workplace. URM groups have reported commonly experiencing microaggressions in school
29 and in the workplace. These experiences of microaggressions have been associated with harmful
30 psychological outcomes including anxiety and depression. Moreover, because microaggressions
31 seem benign, they are rarely reported in the workplace.³⁹ The absence of a supportive affinity
32 community may lead a student to experience an estrangement process, which begins with feelings
33 of alienation that evolve into disillusionment and emotional rejection, and end with the student
34 physically rejecting the campus environment and withdrawing from the institution.⁴⁰

35 36 ADDITIONAL CONSIDERATIONS FOR PATHWAY PROGRAMS

37
38 As the focus of this report is on existing promising practices to promote a diverse medical
39 workforce, the Council would like to address the importance of gender equity across medical
40 specialties. Table 3 highlights the gender imbalances among the medical specialties according to
41 the 2018 National GME Census, which is compiled by the AMA and the AAMC. It is worth noting
42 the lack of data on physicians who identify as non-binary when evaluating the balances in the
43 specialties.

Table 3 Top Medical Specialties by Gender, 2018-2019

Female-dominated specialties		Male-dominated specialties	
Obstetrics and gynecology	83.4%	Orthopaedic surgery	84.6%
Allergy and immunology	73.5%	Neurological surgery	82.5%
Pediatrics	72.1%	Interventional radiology (integrated)	80.8%
Medical genetics and genomics	66.7%	Thoracic surgery	78.2%
Hospice and palliative medicine	66.3%	Pain medicine	75.3%
Dermatology	60.8%	Radiology	73.2%

Source: 2018 National GME Census

While efforts are underway to increase diverse representation in orthopaedic surgery and radiology, recent attention has also been given to the dramatic decline of men in obstetrics/gynecology. In an effort to identify how to recruit more male students into the field of obstetrics/gynecology, a study was conducted to identify when students make their decisions on career choice and found that >70% of obstetrics/gynecology residents decided to pursue the specialty during or after their third-year clerkship.⁴¹ Another study found that 78% of male students believed their gender adversely affected their obstetrics/gynecology clerkship experience.⁴² The authors recommended the following efforts to increase representation of men in obstetrics/gynecology: improving the quality of the obstetrics/gynecology clerkship experience, engaging students early in their medical school careers, and frankly addressing gender and lifestyle issues that dissuade students from choosing obstetrics/gynecology.

RELEVANT AMA POLICY

Our AMA has a number of existing policies and directives that are relevant to the topic of pathway programs; these are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

There is limited evidence on the effectiveness of pathway programs and more rigorous evaluation is needed. That said, the following promising practices to increase diversity across the various educational settings are supported in the literature: targeted recruitment; revised admissions policies; summer enrichment programs; and comprehensive programs that integrate multiple interventions such as financial, academic, and social support.⁴³ Snyder et al. found that “high quality studies suggest that pipeline program interventions can exert a meaningful, positive effect on student outcomes.”⁴⁴ The limited evidence available provides reason to be optimistic that these programs are beneficial. For example, a study of three HCOP projects in Kentucky, Tennessee, and Virginia during the years 1990-1999 found that students who participated in HCOP programs were likely to enroll in college (93 percent), major in a health profession program (77 percent), and graduate (58 percent). A total of 87 percent of those who graduated from college were enrolled in a health professions program.⁴⁵ Efforts to increase diversity in medicine are needed across multiple levels. Where legally possible, institutions should utilize affirmative action policies to bolster efforts to increase diversity in medicine. University leaders committed to diversity should select deans of their medical programs with a record of active support in this area. Medical programs, through their leaders, at the school and department levels, should support continuing pathway efforts by making statements of support, by cultivating and funding programs that support a culture of diversity on campus, and by recruiting faculty and staff who share this goal. Policymakers at the state level must work to alleviate pre-K-12 educational disparities and improve the college readiness of URM students. Additionally, the efforts to increase gender equity across medical specialties should be encouraged as diverse learners add value to medical education and research

environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.

The Council on Medical Education therefore recommends the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, sexual orientation, and gender identity due to structural racism and other systems of oppression. (New HOD Policy)
2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity. (New HOD Policy)
3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. (New HOD Policy)
4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. (New HOD Policy)
5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows: (4) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support historically underrepresented groups in medicine, by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this and strategies to accomplish that goal. (5) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of minoritized and marginalized patient populations. (Modify Current HOD Policy)
6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights (3) by addition to read as follows: Our AMA will support and encourage the U.S. Department of Education to develop policies and initiatives to 1) increase the high school graduation rate among historically underrepresented students 2) increase the number of historically underrepresented students participating in high school Advanced Placement courses and 3) decrease the educational opportunity gap. (Modify Current HOD Policy)
7. That our AMA amend Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,” by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine~~

- 1 ~~and the biomedical sciences, with a focus on assisting such programs by identifying best~~
2 ~~practices and tracking participant outcomes; and.~~ (Modify Current HOD Policy)
3
4 8. That our AMA reaffirm Policy D-200.982, “Diversity in the Physician Workforce and
5 Access to Care.”

Fiscal note: \$5,000.

APPENDIX: RELEVANT AMA POLICY

D-200.982, Diversity in the Physician Workforce and Access to Care

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

D-200.985, Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

D-305.972, Title VII Funding

Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of \$300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.

H-180.944, Plan for Continued Progress Toward Health Equity

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

H-200.951, Strategies for Enhancing Diversity in the Physician Workforce

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

H-350.960, Underrepresented Student Access to US Medical Schools

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

H-350.970, Diversity in Medical Education

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

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

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Code of Ethics 8.5, Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations. This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-JUN-21

Subject: Council on Medical Service's Sunset Review of 2011 House Policies

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA's policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5

6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position
9 shall reset the sunset "clock," making the reaffirmed or amended policy viable for another ten
10 years.
11

12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
15 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
16 asked to review policies shall develop and submit a report to the House of Delegates
17 identifying policies that are scheduled to sunset; (d) For each policy under review, the
18 reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset
19 the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like
20 policy; (e) For each recommendation that it makes to retain a policy in any fashion, the
21 reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall
22 determine the best way for the House of Delegates to handle the sunset reports.
23

24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
25 than its ten-year horizon if it is no longer relevant, has been superseded by a more current
26 policy, or has been accomplished.
27

28 4. The AMA councils and the House of Delegates should conform to the following guidelines for
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
32 House of Delegates Reference Manual: Procedures, Policies and Practices.
33

34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
35

36 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Council on Medical Service recommends that the House of Delegates policies that are listed in
 4 the appendix to this report be acted upon in the manner indicated and the remainder of this report
 5 be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-125.992	Opposition to Prescription Prior Approval	Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)	Retain. Still relevant.
D-165.985	Evolving Internet-Based Health Insurance Marts	Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

Policy #	Title	Text	Recommendation
			E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-385.960	Appropriate Payments for Vaccine Price Increases	Our AMA will work with national specialty societies to educate physicians to include language in their health insurer contracts to provide for regular updating of vaccine prices and payment levels, which should include	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		real-time adjustments in vaccine pricing. (Res. 807, I-11)	
D-390.958	The Impact of National Physician Payment Reductions on the National Unemployment Rate	Our AMA will expand its previous studies on the economic impact on the medical practice for the purpose of developing data on the negative economic impact on physician practice employees and communities of incremental SGR cuts and will include in future communications with the US Congress, other stakeholders, and the American people, data-driven information on the national economic impact, including the impact from potential loss of employment of medical practice employees and others, due to payment decreases for physician practices. (Res. 218, I-11)	Rescind. The SGR was repealed in 2015. Moreover, the AMA regularly conducts economic analyses that inform AMA advocacy on behalf of physician practices, including a COVID-19 Physician Practice Financial Impact Survey and Changes in Medicare Physician Spending During the COVID-19 Pandemic .
D-400.991	gCPT Modifiers	(1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers. (2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers. (3) Our AMA use the available information to engage in discussions with payers. (4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators. (Sub. Res. 808, I-01; Modified: CMS Rep. 7, A-11)	Rescind. Superseded by Policy D-70.971 which states: (1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers. (2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate. (3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans. (4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers. (5) Our AMA will include in its model managed care contract, provisions that will require

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			managed care plans to adhere to CPT rules concerning modifiers. (6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers. (7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions. (8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.
D-400.994	Conscious Sedation	Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., “conscious sedation”). (Res. 107, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Directive accomplished. New CPT codes for moderate sedation were implemented and RUC recommendations were adopted by CMS in 2017.
D-435.996	Malpractice Insurance Rate Increases and Physician Reimbursement	Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
D-70.983	Inappropriate Bundling of Medical Services by Third Party Payers	Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate	Retain. Still relevant.

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		bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and. (6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-100.964	Drug Issues in Health System Reform	The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package. (2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited. (3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices. (4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the	Retain-in-part. The following subsections should be rescinded for the reasons provided below. Policy H-100.964 should otherwise be retained as still relevant. (4) Policies H-120.974 and H-125.992 have since sunsetted. (8) Superseded by Policy H-35.999. (9) Policies H-115.995 and H-115.997 have since sunsetted. (10) Superseded by Policy H-125.989. (15) Superseded by Policy H-120.988. (17) Policy H-120.983 has since sunsetted.

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		substitution of FDA B-rated generic drug products. (5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991. (6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978. (7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs. (7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information. (8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance. (9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs. (10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic	

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		incentives can interfere with pharmacist professional judgment. (11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling. (12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities. (13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities. (14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses. (15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs. (17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS	

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		Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)	
H-130.945	Overcrowding and Hospital EMS Diversion	It is the policy of the AMA: (1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds; (2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department; (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups; (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities; (5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and (6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions. Citation: (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02;	Retain. Still relevant.

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		Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11	
H-155.974	Excessive Regulatory Costs	Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals, (2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated; (3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and (4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-165.862	Evolving Internet-Based Health Insurance Marts	Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839 , which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange

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			and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion

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			of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
H-180.948	Opposition to Incentives for Care in Non-Physician Clinics	Our AMA will communicate with large insurance companies that providing incentives to patients toward non-physician clinics outside the primary care physician relationship can lead to decisions made on limited information, duplication of testing and procedures, ultimately higher health care costs and a reduction in the quality of health care for the patients of America. (Res. 708, A-11)	Retain. Still relevant.
H-185.943	Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes	Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans. (Res. 119, A-11)	Retain. Still relevant.
H-185.985	Internal Guidelines Used by Third Party Payers to Determine Coverage	Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-185.984 , which supports 24-hour-a-day access to patient coverage and benefits information.
H-200.995	Federally Funded Clinic Programs	Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers. (2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and	Retain. Still relevant.

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		Medically Underserved Areas. The medical community and local residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard. (3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need. (4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area's designation, so that federal resources are not called on to duplicate services. (5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential. (6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-215.964	Patient Identification Wrist Bands	Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used; (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient's name, allergies and those with identified greater fall risk; and (3) will actively pursue national standardization of	Retain. Still relevant.

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		color-coded wristbands in hospital settings. (Res. 727, A-07; Appended: Res. 720, A-11)	
H-215.971	Standardization of Emergency Paging Nomenclature	Our AMA urges the development of standardized emergency paging nomenclature for hospitals. (Sub. Res. 805, A-00; Reaffirmation A-09; Reaffirmation A-11)	Retain. Still relevant.
H-215.984	Duplicate Bureaucratic Regulations	Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-215.994	Subrogation by Hospitals	Our AMA urges hospitals to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policy holder prior to initiating legal action against a physician in the name of the hospital. (Res. 2, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-215.996	Compensation for Service on Government Mandated and Funded Hospital Committees	Our AMA believes that federal or third party funds provided for reimbursement of physicians serving on mandated hospital review committees should not be diverted by the hospital for other purposes. (CMS Rep. H, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.930	Regulatory Standards Should be Evidence-Based	Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be	Retain. Still relevant.

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		appended to the documentation for every clinical standard imposed on health care institutions and providers. (Res. 727, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-220.950	Medical Staff Involvement in Hospital Compliance With Accrediting Organization Standards Plans of Action to Correct Deficiencies	Our AMA: (1) adopts the policy that a hospital medical staff must be appropriately involved in a surveyed organization's development of a plan of action to correct a deficiency and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish processes to ensure appropriate medical staff input into the development of a plan of action to correct a deficiency; and (3) urges accrediting organizations to work to ensure that these principles are part of their accreditation standards. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.953	Quality Improvement Requirements for Leadership Structures of Health Care Organizations	Our AMA supports the following concepts for incorporation in The Joint Commission's accreditation programs for health care organizations: (1) establish accreditation programs with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care; (2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the patients served by these professionals and the prevailing standards of practice; (3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services; (4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen; (5) establish accountability of the management and governance elements	Retain. Still relevant.

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		of a health care organization to its professional staff of physicians and nurses; and (6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	
H-220.995	Hospital Guidelines Impact Statement	Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent	Retain. Still relevant.

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		exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights. (BOT Rep. 2, I-11)	
H-225.972	AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs	It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-235.974	Autonomy of the Hospital Medical Staff	Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-240.997	Patient Signatures for Medicare Payment	Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by	Retain. Still relevant.

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		CMS for Medicare payment for inpatient hospital care. (Res. 15, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-25.989	Long-Term Care Prescribing of Atypical Antipsychotic Medications	Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with “black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare.” (Res. 819, I-11)	Retain. Still relevant.
H-285.920	Criteria for Level of Care Status	(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions; (b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances; (c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment; (d) Level of care guidelines should be developed under the direction of actively practicing physicians; (e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;	Retain. Still relevant.

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		(f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus; (g) Level of care guidelines should be reviewed and updated; and (h) Level of care guidelines should allow for a timely appeal process. (2) It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-285.921	Managed Behavioral Health Organizations (MBHOs)	It is the policy of our AMA that, when requested, Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient's permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient's treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient's health care needs in optimal fashion. (Res. 702, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-290.981	Out-of-State Medicaid Patients	The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient's state of residency, as long as the physician or provider is credentialed where the care is rendered. (Res. 136, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmation A-11)	Retain. Still relevant.
H-330.891	Payment and Coverage for Voluntary Discussions of End-of-Life Issues	Our AMA encourages the Centers for Medicare & Medicaid Services to designate voluntary discussions of end-of-life issues as covered services as part of the 2012 Medicare Physician Fee Schedule rule. (Res. 225, A-11)	Rescind. Accomplished in 2019 when the Centers for Medicare & Medicaid Services began paying for advanced care planning using CPT codes 99497 and 99498.
H-330.954	Mandatory Transmission of	Our AMA opposes the policy of local Medicare carriers of mandating that physicians choose between electronic	Retain. Still relevant.

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	Electronic Claims	remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	
H-340.997	Medicare Preauthorization Review	Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-345.976	Medicaid Coverage of Adults in Psychiatric Hospitals	1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders. 2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes. 3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (CMS Rep. 3, A-11)	Retain. Still relevant.
H-35.992	Reimbursement for Allied Health Personnel	Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain. Still relevant.
H-380.995	Insurance Carrier Terminology	Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed:	Rescind. Superseded by Policy H-390.865 , which calls for a universal EOB to be issued to both the patient and the physician that includes an explanation of billed, covered and patient responsibility amounts.

Policy #	Title	Text	Recommendation
		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-383.994	Managed Care Plans and the Right to Set Fees	Our AMA opposes any government or hospital requirement that a hospital-based physician must accept the terms of any managed care plan accepted by the hospital. (Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.916	Reimbursement for Office-Based Surgery Facility Fees	Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities. (Res. 716, A-11)	Retain. Still relevant.
H-385.917	Interpreter Services and Payment Responsibilities	Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. (CMS Rep. 5, A-11)	Retain. Still relevant.
H-385.925	Selective Revenue Taxation of Physicians and Other Health Care Providers	Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 6, I-11)	Retain. Still relevant.
H-385.932	Contact Capitation Contracts	Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		ability to provide quality patient care. (CMS Rep. 1, A-01; Modified: CMS Rep. 7, A-11)	
H-385.940	CPT Codes for Evening and Night Services	Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.967	Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims	It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: Res. 216, A-11)	Retain. Still relevant.
H-385.968	Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital	Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.970	Payment of Physicians' Services for Patients in Observational or Short Stay Units	Our AMA supports seeking reimbursement from all third party payers for physicians' services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.995	Manipulative Casting of Congenital Deformities of the Extremities	Our AMA encourages all third party payers to classify manipulative casting of congenital deformities of the extremities as a surgical procedure, whether performed in the office or hospital. (CMS Rep. L, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.889	Medicare Reimbursement of Telephone Consultations	It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence. (CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmation A-07; Reaffirmed in lieu of Res. 824, I-11)	
H-390.895	Medicare Patient Surveys	It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.901	Medicare Outpatient Service Charge Limit	Our AMA vigorously opposes the Medicare Part B Policy of Outpatient Physician Charge Limit. (Res. 70, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.906	Medicare Notification of Payment	Our AMA requests CMS to direct Medicare Part B carriers to furnish all physicians with an Explanation of Medicare Benefits on all claims whether assigned or nonassigned. (Res. 62, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-405.980	Caller Identification	Our AMA, based on the concerns of protecting physicians' privacy,	Rescind. No longer relevant.

Policy #	Title	Text	Recommendation
		supports efforts to allow individuals to block caller identification at no cost to the caller. (Sub. Res. 225, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-45.986	Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft	Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as “non-scheduled.” (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-45.997 , which supports legislation to provide immunity to physicians providing care during an in-flight medical emergency.
H-450.961	Health Plan “Report Cards”	The AMA: (1) supports the development and appropriate use of health plan performance standards; (2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures; (3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results; (4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures; (5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles: (a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.	Retain-in-part. The text of the policy remains relevant and should be retained. To better reflect the content of the policy, the title should be amended by addition and deletion as follows: ~~Health Plan “Report Cards”~~ Health Plan Performance Measures

Policy #	Title	Text	Recommendation
		(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential. (c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures. (d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services. (e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged. (f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed. (g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status. (h) Health plan performance data that are self-reported by health plans shall be verified through external audits. (i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public. (j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release. (k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed. (l) The validity and reliability of health plan performance measures shall be evaluated regularly. (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-11)	
H-450.975	Definition of Quality	Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		to which care services influence the probability of optimal patient outcomes. (CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-450.976	Corrective Action and Exclusive Contracts	It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.984	Access to Physician Services in Rural Health Clinics	Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.997	Access to and Quality of Rural Health Care	(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97;	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-478.989	Biometric Technologies Used to Enhance Security	Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)	Retain. Still relevant
H-478.996	Medical Care Online	It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-70.917	Ensuring CPT Usage of the Term Physician is Consistent with AMA Policy	1. Our AMA will ensure that CPT employ the term “physician” consistent with our AMA’s policy in all internal and external communications, publications and products. 2. As a condition for licensure of CPT intellectual property by outside entities, references to the term “physicians” within CPT must remain consistent with our AMA’s policy, and the AMA will take appropriate enforcement action against violators. 3. Our AMA will ensure that the CPT code set continues to be applicable and relevant to physicians and qualified healthcare professionals who may report the professional services described therein. (Res. 602, I-11)	Retain. Still relevant.
H-70.974	CPT Coding System	1. The AMA supports the use of CPT by all third-party payers and urges them to implement yearly changes to CPT on a timely basis. 2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient’s insurance. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11)	Retain. Still relevant.

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Continuity of Care for Patients Discharged from Hospital Settings
(Resolution 212-A-19, Second Resolve)
(Reference Committee A)

EXECUTIVE SUMMARY

Medications are frequently prescribed or changed during hospital discharge, and although medication reconciliation is used by hospitals to boost adherence after discharge, barriers to filling or refilling hospital discharge medications remain. Some discharge prescriptions go unfilled due to mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record or other easily accessible tool. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to adverse tiering or prior authorization.

The Council researched numerous strategies employed by hospitals to ensure continuity of care after hospital discharge, as well as health information technology solutions such as real-time pharmacy benefit (RTPB) tools. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part, because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that the American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. Additional report recommendations support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications and call for AMA advocacy with the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services on RTPB technology.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-JUN-21

Subject: Continuity of Care for Patients Discharged from Hospital Settings
(Resolution 212-A-19, Second Resolve)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the 2019 Annual Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 212, which was introduced by the New York Delegation and directed our American Medical Association (AMA) to advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management (PBM) companies, health insurance companies, and other payers after hospital discharge. The referred second resolve clause was crafted by the reference committee and was assigned by the Board of Trustees to the Council on Medical Service for a report back.

This report discusses strategies to ensure continuity of care and safe transitions after hospital discharge; highlights real-time pharmacy benefit (RTPB) tools intended to generate cost and coverage data at the point of care; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The intent of the reference committee's second resolve clause of Resolution 212-A-19 is to ensure continuity of care for patients transitioning from a hospital to an outpatient setting by ensuring coverage of hospital prescribed medications that are to be continued after discharge. Adherence to medications has long been recognized to be a key component of effective medical treatment and is associated with decreases in morbidity, mortality, and hospitalizations. As discussed in [Council on Medical Service Report 7-I-16, Hospital Discharge Communications](#), patients often experience medication-related problems during the period following hospital discharge, and more than a third of post-discharge follow-up testing is never completed.

Medications are frequently prescribed or changed during care transitions, including hospital admissions and discharges, which can be confusing for patients and put them at risk of nonadherence. Medication reconciliation—the process of reviewing and resolving discrepancies between medications a patient is using and new medications that have been ordered for the patient—is employed by hospitals during the discharge process to boost adherence to prescribed regimens and prevent adverse health outcomes. Medication reconciliation is built into the National Patient Safety Goals developed by The Joint Commission,¹ which recognizes that organizations face challenges with medication reconciliation and that its effectiveness will increase as more advanced health information technology (IT) systems are adopted.²

Importantly, barriers to filling or refilling hospital discharge medications remain even when medications have been effectively reconciled. Some discharge prescriptions go unfilled due to

mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record (EHR) or other easily accessible tool. Accordingly, access to outpatient drug formularies is vital to medication management and continuity of care during patient hospitalizations and the period after discharge.

Formulary systems can be complicated and confusing for both patients and physicians. First, hospital inpatient formulary systems have traditionally been distinct from health plan outpatient formularies, which differ among themselves and are frequently adjusted (even during the benefit year). Hospitals that have merged with or grown into larger health systems, including those that have integrated with payers, may have multiple formularies in place, each of which is continuously evaluated against lists of available medications and prescribing guidelines.³ Hospital formulary systems are managed by a pharmacy and therapeutics committee (P&T committee), which oversees medication management and use at the hospital. A P&T committee usually reports to the medical staff, which should have final approval over the hospital's medication-use policy.⁴ Because hospitals/health systems are unable to procure, stock and administer all available medications, most hospital formularies make one or two medications available for each therapeutic class. A hospital formulary may also restrict the prescribing of some medications to certain specialties, although medications not available on the formulary can generally be requested.⁵

Upon admission to a hospital, hospitals may substitute a patient's home (outpatient) medication through approved therapeutic interchange if that medication is not part of the hospital's formulary. Ideally, at the time of discharge, patients should be reconciled back to their home medications to ensure continued adherence. Hospital physicians may also prescribe new medications intended for use after discharge, and those prescriptions may be based on the hospital formulary. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to restrictions such as adverse tiering or prior authorization (PA). Accordingly, patients may be discharged with prescriptions that will not be adequately covered or paid for by their pharmacy benefits plan.

Strategies to ensure continuity of care after hospital discharge

Strategies to ensure continuity of care after hospital discharge are numerous and varied and include pharmacist interventions to address medication and/or insurance issues, as well as discharge checklists that require confirmation of coverage of prescribed discharge medications. Examples of care transition interventions centered on discharge include the SafeMed care transitions model and Project BOOST (Better Outcomes for Older Adults through Safe Transitions). SafeMed uses intensive medication reconciliation and home visits to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its Steps Forward™ initiative, the AMA developed a [module](#) for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Among other interventions, Project BOOST identifies patients at high risk of hospital readmission and follows up with them to monitor adherence after discharge.

Some hospitals have established bedside medication delivery services to help mitigate the number of hospital prescriptions that go unfilled after discharge. Also known as "meds-to-beds" or "meds-in-hand" interventions, these services are provided by hospitals in partnership with their outpatient pharmacies, which are able to access outpatient formulary information⁶ and coordinate PA requirements. A study of one hospital's "meds-in-hand" process highlighted use of the hospital

1 outpatient pharmacy to reliably verify insurance coverage of prescribed outpatient medications, and
2 further posited that patients may incur lower costs from receiving medications from the outpatient
3 pharmacy rather than the inpatient pharmacy.⁷ Another study found that a pediatric “meds-in-hand”
4 project increased the proportion of patients discharged in possession of their medications and may
5 have decreased unplanned visits to the emergency department in the 30 days after discharge.⁸ In
6 addition to bedside medication delivery services, some hospitals provide a transitional supply of
7 medications to high-risk uninsured patients at the time of discharge and also help patients obtain
8 medications through patient assistance programs.⁹ Many hospitals routinely follow up with patients
9 after discharge to check on medication access and adherence.

10 11 *Real-time pharmacy benefit (RTPB) tools*

12
13 Transparency of drug coverage and formulary information in EHRs could prove useful in
14 preventing medication nonadherence and treatment abandonment during the post-discharge period.
15 To ensure such transparency, accurate, real-time information needs to be available at the point of
16 prescribing. Although the AMA has been advocating that insurers, PBMs, and EHR vendors move
17 quickly to develop point-of-care software that provides patient coverage and cost-sharing
18 information, problems remain. Specifically, there are concerns with the accuracy of Formulary and
19 Benefit (F&B) files based on how often payers update their formularies and provide the F&B
20 update files to intermediaries and EHR vendors. Notably, F&B files are static and may not
21 represent the most current formulary data. Moreover, these files do not provide drug coverage
22 information at a granular, patient-specific level of detail.

23
24 In contrast, real-time pharmacy benefit (RTPB) technology holds promise for improving continuity
25 of care for patients discharged from the hospital setting. Although RTPB tools are relatively new
26 and have not yet been widely implemented, adoption continues to improve, and prescribers should
27 have greater access to real-time benefit and coverage restriction information at the point of care
28 through RTPB tools in the near future. To accelerate the use of electronic RTPB tools in the
29 Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) requires every
30 Part D plan to support one or more real-time benefit tools capable of integrating with at least one
31 e-prescribing system or EHR, effective January 1, 2021. While this requirement falls short of
32 ensuring that all prescribers have access to RTPB information for every patient they encounter, it is
33 a positive step for increasing RTPB tool adoption and improving access to benefit information. In
34 addition, CMS will require Part D plans to offer a consumer-facing RTPB tool starting
35 January 1, 2023, which will allow patients to obtain information about medication costs and
36 possible lower-cost alternatives under their prescription drug benefit plan.¹⁰

37
38 Over the past few years, the National Council for Prescription Drug Programs (NCPDP) has been
39 developing an electronic standard for the communication of real-time prescription drug coverage
40 and pricing information, including therapeutic alternatives, between payers and prescribers. The
41 AMA actively participates in the NCPDP effort to ensure that the standard will provide the
42 prescription drug information that physicians need at the point of prescribing. Based on progress of
43 the NCPDP work, it is expected that an RTPB standard will be recommended to CMS for an
44 eventual federal mandate under the Part D program in late 2021. Because there are several
45 proprietary RTPB systems on the market, the AMA supports a standardized RTPB process that
46 allows providers to access information for all of their patients, regardless of what payer the patient
47 is covered under or what EHR/e-prescribing system is used by the provider. The AMA also
48 strongly advocates for alignment between the prescription drug data offered in physician-facing
49 and consumer-facing RTPB tools, as any discrepancies in the pricing or coverage information
50 presented to these different audiences will result in increased administrative burdens for physicians,
51 patient dissatisfaction, and mutual confusion.

AMA ACTIVITY

The AMA engages in robust federal and state advocacy on a range of policy issues relevant to improving continuity of care and preventing treatment delays after hospital discharge. The Council has previously discussed concerns related to transparency in drug formularies, which make it exceedingly difficult for physicians to determine which treatments are preferred by a particular health plan at the point-of-care (see [Council on Medical Service Report 5-A-19, The Impact of Pharmacy Benefit Managers on Patients and Physicians](#)). For patients, lack of transparency in drug coverage information may lead to treatment delays as well as being unaware of their cost-sharing responsibilities which can affect medication adherence. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, [TruthInRx.org](#), in 2016. At the time this report was written, nearly 350,000 individuals had signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency. The AMA has also developed model state legislation which addresses issues related to stabilized formularies and cost transparency.

To educate the public about problems associated with PA and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a second grassroots website, [FixPriorAuth.org](#), in 2018. This site showcases an array of stories about PA requirements delaying care, including [one video](#) about a patient who had undergone heart stenting but was unable to fill a discharge prescription for a blood thinner because of a PA hurdle. The physician was unaware that the insurer would not approve the prescription, and the patient ended up back in the hospital after suffering another heart attack.

More broadly, the AMA is very active in advocating for a reduction in both the number of physicians subjected to PA and the overall volume of PA (see Council on Medical Service Report 4-JUN-21, Accountability in Prior Authorization). In January 2017, the AMA and a coalition of state and specialty medical societies, national provider organizations and patient organizations developed and released a set of 21 [Prior Authorization and Utilization Management Principles](#) intended to ensure that patients receive timely and medically necessary care and medications and reduce administrative burdens. Four of these principles speak directly to continuity of care, and Principle #8 addresses formulary data transparency in EHRs. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association in a [Consensus Statement](#) outlining a shared commitment to industry-wide improvements to PA processes and patient-centered care. The Consensus Statement underscores that continuity of care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage change and/or a change of health plan, and also addresses making PA requirements and other formulary information electronically accessible in EHRs. Additionally, the AMA has model legislation addressing PA and works closely with many state medical associations to enact legislation.

The AMA continues to advocate with the Office of the National Coordinator for Health Information Technology (ONC) and CMS around opportunities to improve health IT and EHRs, including standards, certification and vendor requirements that will help improve interoperability, EHR performance and data usability. As stated previously, the AMA participates in the NCPDP effort to advocate for physicians' interests and supports a standardized RTPB process that ensures alignment between physician-facing and patient-facing RTPB tools.

1 RELEVANT AMA POLICY

2
3 The AMA has extensive policy on hospital discharge and medication reconciliation. Policy
4 D-160.945 advocates for timely and consistent communication between physicians in inpatient and
5 outpatient settings to decrease gaps in care coordination and improve quality and patient safety.
6 Evidence-based principles of discharge and discharge criteria are outlined in Policy H-160.942.
7 Policy H-160.902, established with [Council Report 7-I-16](#), encourages the development of
8 discharge summaries that are presented to physicians in a meaningful format that prominently
9 highlight salient patient information, such as the discharging physician's narrative and
10 recommendations for ongoing care. This policy also encourages hospital engagement of patients
11 and families in the discharge process, supports implementation of medication reconciliation as part
12 of the discharge process, and encourages patient follow-up in the early time period after discharge.
13 Policy D-120.965 also supports medication reconciliation to improve patient safety.

14
15 The AMA also has substantial policy on drug plans and formularies. Policy D-330.910 states that
16 the AMA will explore problems with prescription drug plans, including issues related to continuity
17 of care, PA, and formularies, and work with CMS and other organizations to resolve them. AMA
18 policy objectives addressing managed care cost containment involving prescription drugs are
19 outlined in Policy H-285.965, which speaks to mechanisms to appeal formulary exclusions and
20 urges pharmacists to contact prescribing physicians if prescriptions violate the managed care
21 formulary so that physicians can prescribe an alternative drug that may be on the formulary. Under
22 Policy H-285.952, the AMA will continue providing assistance to state medical associations in
23 support of state legislative and regulatory efforts to ensure continuity of care protections for
24 patients in an active course of treatment.

25
26 Policy H-125.979 directs the AMA to: work with PBMs, health insurers and pharmacists to enable
27 physicians to receive accurate, real-time formulary data at the point of prescribing; promote that, in
28 the event that a drug is no longer on the formulary when a prescription is presented, notice of
29 covered formulary alternatives shall be provided to the prescriber so that appropriate medication
30 can be provided; and promote the value of online access to up-to-date and accurate prescription
31 drug formulary plans from all insurance providers. [Council on Medical Service Report 5-A-19](#)
32 established Policy D-110.987, which supports regulation of PBMs and improved transparency of
33 PBM operations, including disclosing formulary information such as whether certain drugs are
34 preferred over others and patient cost-sharing responsibilities, which should be made available to
35 patients and to prescribers at the point-of-care in EHRs. Policies D-125.997 and H-185.942 support
36 protecting patient-physician relationships from interference by PBMs and payers. Policy
37 H-125.979 aims to prohibit drugs from being removed from the formulary or moved to a higher
38 cost tier during the duration of a patient's plan year.

39
40 Drug formularies, P&T committees, and therapeutic interchange are addressed in Policy
41 H-125.991, which outlines standards that must be satisfied in order for drug formulary systems to
42 be acceptable. This policy also insists that health plans have well-defined processes for physicians
43 to prescribe non-formulary drugs when medically indicated and discourages the switching to
44 therapeutic alternates in chronic disease patients who are stabilized on drug therapy. Finally, the
45 AMA has numerous policies on usability and interoperability of EHRs, including Policy D-478.995
46 on health IT which, among other directives, supports AMA advocacy for standardization of key
47 elements of the EHR.

1 DISCUSSION
2

3 Although the referred second resolve clause of amended Resolution 212-A-19 focuses on
4 continued coverage of prescribed discharge medications, the Council believes that continuity of
5 care for medical services is also vital to improving the health outcomes of patients transitioning out
6 of hospitals. The Council recognizes that, because inpatient and outpatient formularies differ,
7 ensuring continuous coverage of medications and medical services is not always feasible, in part
8 because some hospital physicians lack access to patients' outpatient formulary information.
9 Accordingly, the Council recommends that our AMA advocate for protections of continuity of care
10 for medical services and medications that are prescribed during patient hospitalizations, including
11 when there are formulary or treatment coverage changes that have the potential to disrupt therapy
12 following discharge.

13
14 The Council recognizes that there are multiple ways for hospitals to carry out medication
15 reconciliation and does not wish to prescribe how this process should be accomplished. Some
16 hospitals assign staff (usually pharmacy staff) to work through coverage issues and facilitate
17 patient access to discharge medications. Others utilize hospital outpatient pharmacies to review
18 coverage and PA requirements during the reconciliation process. The Council recommends
19 supporting—but not requiring—medication reconciliation that includes confirmation that
20 prescribed discharge medications will be covered by a patient's health plan and completion of PA
21 requirements.

22
23 Aside from medication reconciliation, the Council identified other innovative strategies employed
24 by hospitals to improve medication adherence after hospital discharge. "Meds-to-beds"/"meds-in-
25 hand" services take a variety of forms and can be administered hospital-wide or for specific patient
26 populations. However, these programs may not be achievable at all facilities, particularly those
27 without an outpatient pharmacy on site. Safety-net hospitals are more likely to provide an initial
28 30-day supply of medications to uninsured patients, and the Council supports these efforts—and
29 broadening them—while acknowledging the cost implications for hospitals. Accordingly, the
30 Council recommends a more general policy statement supportive of strategies to address coverage
31 barriers and facilitate patient access to prescribed discharge medications, such as bedside
32 medication delivery services and the provision of transitional supplies of discharge medications.

33
34 The Council believes that RTPB systems hold promise for improving continuity of care during the
35 discharge period and looks forward to the release of an RTPB standard, widespread implantation of
36 this technology in physicians' and hospitals' EHR systems, and ongoing evaluations of and
37 improvements to these tools to ensure that RTPB technology meets the needs of prescribers. At this
38 time, the Council believes it is premature to require EHR vendors to incorporate RTPB for
39 certification. Instead, the Council recommends that our AMA advocate that ONC and CMS work
40 with physician and hospital organizations, and health IT developers, to identify RTPB
41 implementations and published standards that provide real-time or near-time formulary information
42 across all prescription drug plans, patient portals and other viewing applications, and EHR vendors.
43 The Council further recommends that any policies requiring health IT developers to integrate
44 RTPB systems within their products do so with minimal disruption to EHR usability and cost to
45 physicians and hospitals. Finally, the Council believes that it is critically important for the data
46 offered on emerging consumer-facing RTPB tools to match the drug pricing and coverage
47 information displayed in physicians' and hospitals' EHRs, as discrepancies will lead to confusion
48 and dissuade both physicians and patients from using these technologies. Accordingly, the Council
49 recommends that our AMA support alignment and real-time accuracy between the prescription
50 drug data offered in physician-facing and consumer-facing RTPB tools.

The Council acknowledges the strength of AMA policy on problems with prescription drug plans and formulary transparency and recommends reaffirmation of Policies H-125.979 and D-330.910. Previous Council reports on [hospital discharge communications](#) and [physician communication and care coordination during patient hospitalizations](#) underscored that consistent physician-to-physician communication across care settings is integral to achieving a safe and efficient discharge process. The Council recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)
2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)
3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)
4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)
5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)
6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy)
7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)

- 1 8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with
2 prescription drug plans, including issues related to continuity of care, prior authorization, and
3 formularies, and work to resolve them. (Reaffirm HOD Policy)
4
- 5 9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and
6 consistent communication between physicians in inpatient and outpatient settings to decrease
7 gaps in care coordination and improve quality and patient safety, and to explore new
8 mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-JUN-21

Subject: Universal Basic Income Pilot Studies
(Resolution 236-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred Resolution 236, which was sponsored by the Medical Student Section and asks that the American Medical Association (AMA) support federal, state, local, and/or private Universal Basic Income pilot studies in the United States that intend to measure health outcomes and access to care for participants.

This report provides background on Universal Basic Income (UBI) proposals, outlines potential funding mechanisms for a UBI program, provides numerous examples of past and current UBI pilot programs and, where available, any resulting outcomes, details relevant AMA policy, and provides recommendations consistent with ongoing AMA advocacy efforts.

BACKGROUND

Some economists and policymakers argue that, although there was strong 3.4 percent growth in gross domestic product (GDP) in 2019 and low rates of unemployment, those numbers conceal the fact that many families are struggling financially. Wage growth remains stagnant, and nearly 1 in 10 employed adults work as contractors with limited job security and therefore employment benefits such as health insurance and long-term financial security. Moreover, the novel coronavirus (COVID-19) pandemic is severely exacerbating these health and economic issues. There have been more than 48 million jobless claims in the US since March. At the time this report was written, about 31.8 million people are receiving unemployment benefits, which equates to about 1 in 5 individuals in the workforce.¹ Simultaneously, the US continues to set record numbers of COVID-19 cases with cases trending upward in 39 states.² In light of the pandemic, the International Monetary Fund projects that growth in the US will fall 8 percent in 2020 and overall worldwide output will fall 4.9 percent.³

UBI is one method that is being suggested as having the potential to address current income inequality and to mitigate the loss of jobs caused by technological advances and COVID-19. UBI is an economic support mechanism typically intended to reach all or a large portion of the population.⁴ It is particularly noteworthy and contrasted with current US welfare programs in that receipt of UBI comes with no or minimal conditions. According to the International Monetary Fund, in formulating a UBI plan, policymakers generally grapple with three primary considerations: who is eligible, the generosity of the UBI transfers, and the fiscal cost.⁵ Some UBI proposals are universal while others are targeted to lower-income populations. Additionally, policymakers must weigh the incentives and disincentives of the generosity of transfers. For example, they must determine how UBI will affect decisions to enter the workforce and the number of hours worked. Finally, and perhaps most importantly, policymakers must determine the fiscal cost of implementing UBI to governments in an environment of limited financial resources.⁶

Proponents of UBI claim that it would help break the poverty cycle and dependency on welfare programs. They claim UBI will give the disadvantaged the time and money to seek higher education and needed job training.⁷ Others claim that UBI would disincentivize work. However, decreased working hours has not been established in UBI trials to date.⁸

Advocates mention that UBI could replace the current complicated safety net. The US has a patchwork benefits system with programs including but not limited to:

- Supplemental Nutrition Assistance Program: Provides nutrition benefits to supplement the food budget of families in need so they can purchase healthy food.
- Temporary Assistance for Needy Families: A time-limited program that assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs.
- Children's Health Insurance Program (CHIP): Provides health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP also covers pregnant women.
- Section 8: Housing choice voucher program assisting low-income families, the elderly, and the disabled, to afford safe and sanitary housing in the private market.
- Earned Income Tax Credit: A refundable tax credit to low- and moderate-income individuals, particularly those with children.
- Special Supplemental Nutrition Program for Women, Infants, and Children: Provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are at nutritional risk.
- Supplemental Security Income: Program providing cash benefits to meet the needs of elderly, blind, and disabled individuals who otherwise have challenges paying for food and shelter.

Every year, the US spends nearly \$1 trillion across dozens of state and federal programs amounting to significant administrative oversight across multiple agencies.⁹ However, some critics of the programs state that the complex network of resources is a consequence of having different programs intentionally target different populations with varying needs and that the purpose of each program is distinct.¹⁰ Critics of UBI state that it amounts to redistribution but does not necessarily advance mobility or represent an investment in human capital. Rather, they believe, society should focus its collective efforts on reforming current safety net programs to better meet their intended goals.¹¹

FUNDING

Regardless of where one stands on UBI, how to pay for it is the primary challenge. Some estimates put the annual price for a US program in the trillions. Presumably, such a high cost would have to be funded through some type of taxation.

Some UBI advocates claim that such a high cost would be offset by savings as fewer people require welfare, food stamps, and other social programs. Moreover, advocates argue, UBI could be funded through savings from averting prisons, emergency care, and homelessness,¹² based on the evidence that high health care spending in the US is a direct result of low social safety net spending.¹³ In fact, the significant literature on social determinants of health (SDOH) establishes a direct link between social factors and health status, and some evidence points to a link between social spending and health outcomes.¹⁴ However, it remains unclear exactly how much low spending on

SDOH impacts health spending and therefore how much overall spending could be reduced in a UBI program.

Former 2020 presidential candidate and current New York City mayoral candidate Andrew Yang has run on a platform of a guaranteed income. Yang's proposal, called the Freedom Dividend, suggested giving \$1,000 per month to all US citizens over the age of 18 unconditionally. Yang proposed funding his UBI proposal through four sources. First, he proposed streamlining and consolidating several welfare programs. Second, he suggested implementing a Value Added Tax of ten percent to generate revenue. Third, he stated that UBI would put money into the hands of American consumers and would thereby generate economic growth. And fourth, he proposed taxing top earners and pollution through such actions as a financial transactions tax and a carbon fee.¹⁵

UBI PILOT PROGRAMS AND RESULTS

Manitoba Basic Annual Income Experiment (Mincome)

In 1975, the Canadian government began the Manitoba Basic Annual Income Experiment (Mincome), which lasted three years. The results of this experiment were published in 2011. Unlike most UBI pilots, Mincome allowed researchers to compare the health of those receiving UBI to the health of similar people not receiving UBI. The experiment involved 1,300 urban and rural families with incomes below \$16,000 in Canadian dollars for a family of four. Families with higher incomes still received the UBI but at a reduced rate. Therefore, working was still rewarded, and the results of the pilot show that the majority of Mincome participants kept working. Importantly, families receiving the UBI had fewer hospitalizations, accidents, and injuries. Additionally, mental health hospitalizations fell dramatically in the population receiving UBI. Further, the high school completion rate for 16- to 18-year-old boys increased, and adolescent girls were less likely to give birth before the age of 25. The experiment was terminated after three years when Canada's governing party changed midway through the proposed duration of the pilot.¹⁶ To date, Mincome remains one of the few UBI experiments measuring any health outcome related data.

Finland's Basic Income Experiment

In 2017, Finland launched a UBI experiment involving a guaranteed tax-free income of about \$590 per month to 2,000 randomly selected unemployed citizens. The trial experiment lasted nearly two years. As researchers explore the effects of the experiment, one general finding is that happiness and overall sense of wellbeing improved. Participants also stated that the income gave them a sense of autonomy and allowed them to return to meaningful activities. Regarding employment, the results are mixed. Employment went up slightly in the second year of the trial but not significantly. Participants stated that there were still no jobs available in the areas in which they were trained. Others noted that, due to the basic income, they were more prepared to take on lower paying jobs to enable them to reenter the workforce.¹⁷

Ontario Basic Income Pilot

In March 2017, the government of Ontario, Canada began the Ontario Basic Income Pilot. The pilot was undertaken in three sites in Ontario with 4,000 low-income individuals participating with an additional 2,000 people participating in the comparison group. The participants were eligible to receive up to \$16,989 per year for a single person, less 50 percent of any earned income or up to \$24,027 per year for a couple, less 50 percent of any earned income. The pilot measured, among other markers, food security, stress and anxiety, mental health, housing stability, and health and

health care usage. Additionally, participants receiving support through social assistance needed to withdraw from those programs to participate and receive the UBI. In 2019, Ontario terminated the pilot earlier than planned two months after a change in the control of the province's government from the Liberal Party to the Progressive Conservatives Party. The new government stated that winding down the pilot will enable participants to transition back to more proven support systems without putting an undue burden on taxpayers.

Stockton Economic Empowerment Demonstration

In February 2019, the city of Stockton, California began giving 125 city residents a guaranteed income of \$500/month for 18 months.¹⁸ The monthly income was unconditional, and it was intended to test UBI as a solution to poverty and inequality. Though the program was scheduled to end in June 2020, it was renewed until January 2021 due to the COVID-19 pandemic. The 125 residents participated in individual onboarding appointments, which included informed consent and benefits counseling. According to the Stockton Economic Empowerment Demonstration (SEED), the purpose of the benefits counseling was to ensure that the participants were aware of any risks associated with the UBI disbursements possibly impacting their health insurance or other benefits such as food stamps or Supplemental Security Income. One of the primary outcomes that the SEED researchers planned to measure was the effect of the UBI on the participants' functioning and well-being. One of the early program results observed was that most recipients spent their money on groceries and utility bills. In the early phase of the program, food spending made up about 30 percent to 40 percent of the spending each month. However, after the pandemic started, the share of food spend increased to almost 50 percent.¹⁹ After initial results were released, a group of mayors announced the formation of the Guaranteed Income Coalition, which is committed to investigating how to successfully build and launch UBI projects in their cities.

In March 2021, SEED released the results from the first year of the experiment. A primary finding is that the individuals who received the monthly UBI payment secured fulltime employment at more than twice the rate of those in the control group. Additionally, within a year, the proportion of recipients receiving the cash payments who had a fulltime job went from 28 percent to 40 percent. Meanwhile, the control group saw a 5 percent increase in full time employment. Another positive finding is that those receiving cash payments reported being less anxious and depressed compared to the control group. As far as how the group spent the money, of the money tracked, recipients spent more on necessities like food (37 percent), home goods and clothes (22 percent), utilities (11 percent), and car costs (10 percent). The recipients spent less than 1 percent of the UBI payment on alcohol or cigarettes. Although the study's sample size is small, the early results indicate that UBI payments give recipients stability and enhance health.^{20 21}

OpenResearch

Another UBI pilot being undertaken is by OpenResearch, a non-profit research lab. The study, which started in 2020, recruited about 3,000 people across two states. It randomly assigned 1,000 of those individuals to receive \$1,000 per month for three years while using the other 2,000 individuals as the control group. Importantly, the pilot will measure health outcomes including health markers (e.g., body mass index, hypertension), healthy behaviors, health insurance coverage, food security, housing quality and stability, physician and mental health care utilization, crime victimization, and mental health.

RELEVANT AMA POLICY

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to provide leadership in addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

The AMA also has strong policy supporting Medicaid. Policy H-290.986 states that the Medicaid program is a safety net for the nation's most vulnerable populations. Moreover, the AMA is committed to expanding Medicaid coverage. In particular, Policy D-290.979 directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. Finally, Policy D-290.985 encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.

DISCUSSION

There are risks to replacing targeted social safety net programs, which protect the most vulnerable, with a UBI program. The AMA strongly supports these existing evidence-based safety net programs. Of note, AMA Ethics Opinion 11.1.1 states that health care is a fundamental human good and the Council believes physicians have a responsibility to work to ensure access to care. The Council advises caution regarding support for any proposal that may have the effect of jeopardizing access to care.

The AMA continues to advocate for Medicaid funding and other safety net program funding. Medicaid and other safety net programs increase vital access to care for patients, reduce the number of uninsured individuals, and improve the lives of working Americans. The Council believes the AMA should continue its efforts to improve upon and expand Medicaid and other programs that improve the health of patients. Therefore, the Council recommends reaffirming the AMA's comprehensive policy on addressing health disparities, the role of Medicaid as a vital safety net program, the AMA's enduring commitment to expanding Medicaid eligibility, and sufficient funding for the program.

An evidence-based method to analyze UBI is currently unavailable. Models have been population-based and generally do not meet minimum standards for randomized control studies. They have also been subject to political influence and change. Experiments are key to understanding how and if UBI would work on a large scale. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects the program would have once implemented. The Council does not believe that there are adequate data to actively support UBI pilots at this time. However, the Council recognizes that UBI may be one of myriad solutions to help address growing inequity and health care disparities. Therefore, the Council recommends that the AMA

actively monitor UBI pilots moving forward, especially pilots that intend to measure the health outcomes and access to care of its participants.

The Council understands that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. Since February 2020, governments all over the world, including the US, have started distributing direct cash payments among large portions of their populations in order to mitigate the loss of jobs and financial disruption of the pandemic. A report from the United Nations recently stated that temporary basic income payments could stem the spread of the pandemic by enabling workers, particularly those living below the poverty line, to stay at home.²² Additionally, Spain started a UBI program offering monthly payments up to \$1,145 to its poorest families in 850,000 households. The program is the largest test of UBI seen thus far. The program is seen as a way to not only soften the impact of the COVID-19 pandemic but also to become a structural instrument of stability in the country. Also, in March 2021, Congress passed, and the president signed into law the third pandemic aid package that once again includes direct payments to millions of Americans. Importantly, the law, the American Rescue Plan, substantially expands the Child Tax Credit and supplements the earnings of families receiving the credit. Under the law, most Americans will receive \$3,000 a year for each child ages 6-17, and \$3,600 per year for each child under 6. The provision lasts one year and will be sent via direct deposit on a “periodic” basis. This provision represents a major expansion of the child tax credit, and the proposed “periodic” payments mirror a UBI payment.²³

As the COVID-19 pandemic and its economic fallout continue, the US and society must consider the appropriate responses to not only the pandemic but also deepened and newly exposed financial inequities. The AMA is committed to following and analyzing the relevant research to confront these issues and propose solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation’s most vulnerable populations. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)
5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

Fiscal Note: Less than \$500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-JUN-21

Subject: Promoting Accountability in Prior Authorization

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates adopted Policy D-320.983, which asks that the American Medical Association (AMA) study the frequency by which health plans and utilization review entities are using peer-to-peer (P2P) review prior authorization (PA) processes, and the extent to which these processes reflect AMA policies, including H-285.987, “Guidelines for Qualifications of Managed Care Medical Directors,” H-285.939, “Managed Care Medical Director Liability,” H-320.968, “Approaches to Increase Payer Accountability,” and the AMA *Code of Medical Ethics* Policy 10.1.1, “Ethical Obligations of Medical Directors,” with a report back to the House of Delegates.

This report provides background on PA, an overview of the P2P PA process, outlines the significant AMA advocacy efforts on PA and utilization management (UM) review, and proposes recommendations to strengthen AMA policy on PA and, in particular, P2P reviews.

BACKGROUND

Health plans employ PA, step therapy, and other forms of UM to control access to certain treatments and reduce health care expenses. The medical literature clearly establishes the time and cost burdens associated with UM requirements on physician practices. UM often involves manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care. More importantly, PA and other UM methods interfere with patients receiving timely and optimal treatment selected in consultation with their physicians. At the very least, UM requirements can delay access to needed care. In some cases, the barriers to care imposed by UM may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful therapies.

PEER-TO-PEER REVIEWS

P2P conversations refer to discussions between a physician and an insurance company physician employee. The discussion generally occurs after an initial PA denial that typically involves questions of medical necessity or treatment requests that are considered investigational. However, numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs. The rationale behind P2P is to provide a more transparent PA process that is collaborative and appropriately follows relevant clinical guidelines. However, for many treating physicians, P2P review simply represents another time-consuming and potentially detrimental use of UM by insurance companies. Peer reviewers can be unqualified to assess the need for services for an individual patient for whom they have minimal information and have never evaluated or spoken with. These issues are exacerbated if physicians are required to participate in P2P for first-line PAs.

RELEVANT AMA ADVOCACY

PA and other UM programs are a high-priority advocacy issue for the AMA. Several current AMA initiatives address the concerns raised in Policy D-320.983 and strengthen the AMA's ability to effectively advocate on UM issues:

1. State Legislative Activity: In response to the numerous concerns raised by AMA members and the Federation of Medicine, the AMA's Advocacy Resource Center works closely with state and specialty medical societies to address PA and other UM-related issues through state legislation. The AMA's model bill on PA, the "Ensuring Transparency in Prior Authorization Act," addresses a variety of concerns related to UM programs, including response timeliness, duration of authorizations, public reporting of UM program results, retroactive denials, and electronic PA. Additionally, the bill states that UM staff have experience treating patients with the medical condition or disease for which the health care service is requested.¹ At the time of writing, there were nearly 40 bills related to PA and step therapy in the state legislatures, several of which are broad reform efforts based on the AMA model bill, as well as several directed at reducing UM requirements for individuals with HIV/AIDS, cancer, substance use disorder and other chronic diseases and conditions. Additionally, as part of the state policymakers' responses to COVID-19, commercial plans and Medicaid in many states were required (or urged) to reduce certain UM requirements to ensure safe access to care during state stay-at-home orders and other restrictions.
2. Prior Authorization and Utilization Management Reform Principles: To improve access to care and reduce practice burdens, the AMA convened a workgroup of state and specialty medical societies, national provider associations, and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common provider and patient complaints associated with UM programs and developed the Prior Authorization and Utilization Management Reform Principles to address these priority concerns. These 21 principles seek to improve PA and UM programs by addressing the following 5 broad categories of concern:
 - a. Clinical validity
 - b. Continuity of care
 - c. Transparency and fairness
 - d. Timely access and administrative efficiency
 - e. Alternatives and exemptions

These "best practice" principles have served as the foundation for an extensive, multi-pronged advocacy campaign to reform and improve UM programs. Workgroup members directly advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and launch a media campaign to raise awareness of the principles and requested reforms.

Additionally, two of the PA principles specifically reference the qualifications that health plan reviewers should possess. Principle 3 states that utilization review entities should offer an appeals system for their UM programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/sub-

specialty for discussion of medical necessity issues. Principle 16 states that, should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Moreover, providers and patients should be notified of decisions on all other appeals within ten calendar days. And all appeal decisions should be made by a provider who is not only of the same specialty and subspecialty, whenever possible, as the prescribing/order physician, but also, the reviewing provider must not have been involved in the initial adverse determination.²

3. The Consensus Statement on Improving the Prior Authorization Process: The release of the 21 PA reform principles initiated meaningful discussions with the health insurance industry about reducing PA burdens. These discussions led to the development of the Consensus Statement on Improving the Prior Authorization Process—created by the AMA, American Hospital Association, America’s Health Insurance Plans, American Pharmacists Association, BlueCross BlueShield Association and Medical Group Management Association. The AMA continues to advocate for insurers to operationalize the concepts outlined in the Consensus Statement in their PA programs.³
4. Prior Authorization Research: The lack of alignment between physician and health plan interests on PA and other UM programs creates significant challenges in achieving meaningful reform on this issue. Recognizing the key role that credible evidence plays in successful advocacy on this topic, the AMA is engaged in research to gather data regarding the impact of PA on patients and physician practices, including an annual physician survey assessing the burdens associated with UM programs.

PA Physician Survey – In conjunction with a market research partner, the AMA fielded a web-based survey of 1000 practicing physicians in December 2019. The survey sample comprised 40 percent primary care and 60 percent specialty physicians and only included physicians who provide at least 20 hours of patient care during a typical week and routinely complete PAs in their practice. Along with gathering data on the impact of PA on both patient access to timely care and practice burdens, the survey also assessed physicians’ perception of the frequency of P2P review requirements and the qualifications of insurer “peers.”

One survey question asked physicians: “How often are you involved in a peer-to-peer review during the prior authorization process?”

- Never – 6%
- Rarely – 30%
- Sometimes – 45%
- Often – 15%
- Always – 3%
- Don’t know – 1%

Another survey question asked physicians: “How has the frequency of peer-to-peer reviews during the prior authorization process changed over the last five years?”

- Increased significantly or increased somewhat – 60%
- No change – 35%
- Decreased somewhat or decreased significantly – 5%

An additional survey question asked physicians: “When completing a peer-to-peer review during the prior authorization process, how often does the health plan’s ‘peer’ have the appropriate qualifications to assess and make a determination regarding the prior authorization request?”

- Always – 2%
- Often – 13%
- Sometimes – 41%
- Rarely – 28%
- Never – 4%
- Don’t know – 11%

Note: Percentages do not sum to 100 percent due to rounding.

DISCUSSION

The Council recognizes the value and importance of the AMA’s current multi-pronged advocacy efforts related to PA and applauds the House of Delegates for highlighting the issue of P2P PA and its effect on physicians and most importantly patients. To continue its effective advocacy efforts regarding PA, the Council recommends reaffirming several AMA policies and recommends a number of new policies specifically related to P2P PA. First, the Council recommends reaffirming Policy H-320.939, which states that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Additionally, the Council recommends reaffirming Policies H-320.948 and H-320.961, which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. Further, the Council recommends reaffirming Policy H-320.949, which states that UM criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore the importance of a clinical basis for health plans’ coverage decisions and policies.

While physicians have the freedom to choose their method of making a living, physicians employed by insurance companies must not have their ethical obligations discharged. Insurance companies know that many patients and physicians do not appeal PA decisions, and even fewer seek an external review. However, when an external review is sought, nearly one-third of external reviews of insurer denials are overturned.⁴ These overturned denials demonstrate that insurers’ processes for determining medical necessity often do not reflect current clinical standards of care. It is imperative to patient safety and quality of care that physicians make utilization review decisions in good faith and follow evidence-based guidelines in their work for insurers. Therefore, the Council recommends reaffirming Policy H-285.939, which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.

Furthermore, the Council recommends addressing the timeframe for PA decisions for P2P discussions. Physicians generally receive the PA decision at the end of the P2P discussion. However, insurers have suggested that plans should have two business days after the P2P to make a decision. A recent operating rule for electronic PA has this longer specification. Specifically, it states that once a health plan receives a complete PA request, including any P2P medical reviews conducted, the health plan must return an approval or denial to such request within two business days.⁵ Further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. The Council believes such mitigating circumstances include instances wherein a physician involved in the P2P discussion requests additional time to read relevant medical literature. Importantly, the Council notes that such an extension shall not be permitted where the PA request is urgent.

As highlighted in Policy D-320.983, care must be taken to ensure that plan reviewers are, in fact, physician peers with the appropriate experience treating the condition in question and from the same specialty or subspecialty. The AMA already has strong policy stating that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review (e.g., Policy H-320.968). Nevertheless, the Council believes that policy should be strengthened to ensure that not only is the reviewing physician of the same specialty and licensed to practice in the jurisdiction, but also has the expertise to treat the medical condition or disease under review according to up-to-date evidence-based guidelines and has knowledge of novel treatments.

Moreover, as directed by Policy D-320.983, the Council highlights Ethics Opinion 10.1 regarding ethical guidance for physicians in nonclinical roles. Ethics Opinion 10.1 states that physicians earn and maintain the trust of their patients and the public by upholding norms of fidelity to patients, on which the physician's professional identity rests, and that, despite not directly providing care to patients, physicians employed by insurers have committed themselves to the values and norms of medicine. Accordingly, the Council recommends that physicians employed by insurance companies must follow current evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.

The Council notes that the AMA's efforts to reduce PA burdens are particularly important during public health emergencies, such as the novel coronavirus (COVID-19) pandemic. Recognizing the enormous strain placed on physicians and the entire US health care system and, more importantly, the impact that delayed care has on patients during the COVID-19 crisis, the AMA and other organizations have successfully advocated for many commercial health plans to temporarily suspend or otherwise adjust PA requirements. Meanwhile, legislators and regulators have reduced PA in both the commercial and Medicaid markets via legislation, executive orders, and waivers. While the AMA strongly supports relaxation in PA requirements during the COVID-19 emergency, there is considerable variation in the adjustments being made across the commercial health insurer market and corresponding effective dates, with some plans quickly reinstating regular PA processes only a few months into the pandemic. The AMA is tracking individual health plan COVID-19-related PA program updates to help physicians stay informed of these rapidly changing policies (see <https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf>). To that end, the Council recommends that the AMA urge temporary suspension of all prior authorizations and calls for the extension of existing approvals during a declared public health emergency.

Finally, the Council notes that PA remains a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As detailed in this report, the AMA prioritizes

PA as one of its key advocacy issues and continues to collaborate with relevant stakeholders to address physician concerns on this topic. The AMA is committed to ensuring that tackling PA and UM issues will continue to be a leading priority for the AMA.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans' coverage decisions and policies. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)
6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)
7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)
8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)

- 1 9. That our AMA continue to advocate for a reduction in the overall volume of health plans’
2 PA requirements and urge temporary suspension of all PA requirements and the extension
3 of existing approvals during a declared public health emergency. (New HOD Policy)
4
5 10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study
6 herein. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

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⁴ Private Health Insurance: Data on Application and Coverage Denials. Government Accountability Office. Available at: <https://www.gao.gov/new.items/d11268.pdf>

⁵ CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule Version PA.2.0. CAQH CORE. Available at: https://www.caqh.org/sites/default/files/core/phase-iv/452_278-infrastructure-rule.pdf

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-JUN-21

Subject: Medical Center Patient Transfer Policies
(Resolution 818-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Interim Meeting, the House of Delegates referred Resolution 818, which was sponsored by the Organized Medical Staff Section. Resolution 818-I-19 asked the American Medical Association (AMA) to: (1) study the impact of “auto accept” policies (i.e., unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients; and (2) advocate that if a medical center adopts an auto accept policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff. Reference Committee J from the 2019 Interim Meeting noted that the resolution simultaneously called for study and new policy, and it emphasized the importance of first studying the issue of auto accept policies. Accordingly, this report explores patient transfer issues, with consideration of potential clinical and financial impacts on patients, and legal, accreditation, and medical staff bylaws implications for physicians and medical centers.

BACKGROUND

Optimal patient health and well-being should be the principal goals of patient transfer, but disagreements can arise in pursuing those goals. Some physicians have observed that medical centers where they practice can automatically accept the transfer of patients with emergent and/or serious conditions, and they have voiced concern that accepting transfer patients without adequate input from the medical staff could jeopardize patient care. The term “auto accept policies” encompasses a variety of medical center policies that address how patients may be “automatically” received at their institutions. For example, one large public health system has implemented an auto accept policy whereby critical care nurses answer phone calls from transferring physicians and accept patient transfers instantaneously--transfer requests are not denied.¹ As part of this system, physicians are paid to be on call and to receive patients from the region. Another medical center will automatically accept any acute critical transfer, with a specially educated triage registered nurse gathering clinical and basic demographic information, locating an accepting physician, and arranging for a bed in the appropriate level of care that will be ready when the patient arrives.² As a third example, another medical center has a pilot program to automatically accept into their Emergency Department (ED) stable patients from other medical centers who need specific services.³ These varied auto accept policies highlight the challenges that are inherent in transferring patients among medical centers and the critical role that physicians must play in these processes.

Any time a patient is transferred from one facility to another, it is essential that both transferring and receiving facilities ensure that there is an accepting physician who is capable of taking responsibility for the care of the transferred patient, and medical centers receiving a transferred patient must affirmatively accept the patient. Under certain conditions, acceptance will be

1 mandatory. Nevertheless, medical center transfer policies, including auto accept policies, that fail
2 to identify the appropriate physicians and their capabilities run the risk of suboptimal care for the
3 patient and delays while the appropriate physicians and resources are identified. In addition,
4 transfers of patients with emergent and/or serious conditions carry implications not only for
5 individual patients, but also public health and legal implications for individual physicians and
6 medical centers, so patient transfer policies must address all of these implications.

7 8 KEY CHALLENGES ARISING WITH PATIENT TRANSFERS

9
10 Interhospital transfer is an understudied area, with little known about institutional variations in
11 information transfer and impacts on patient outcomes.⁴ A recent survey of 32 tertiary care centers
12 in the United States studied communication and documentation practices during interhospital
13 patient transfers and found that practices vary widely among tertiary care centers, and the level of
14 transfer center involvement in oral and written handoff was inconsistent.⁵ Moreover, patients may
15 be transferred from one medical center to another for a variety of reasons, including to receive
16 specific expert medical services such as monitoring, tests, or procedures, or to accommodate
17 patient or family preference.⁶ With a variety of specialists involved in the care of patients with
18 emergent and/or serious conditions requiring transfer, communication and coordination are critical,
19 but complicated.⁷ Often, the physicians who will be directly caring for a transferred patient want to
20 be involved early in the transfer process to ensure that their specific questions are answered.⁸ In an
21 attempt to address transfer challenges, some hospitals have established dedicated call centers, often
22 staffed by senior-level nurses, to coordinate communication between accepting and receiving
23 physicians.⁹ However, studies have found such call centers to be highly variable in their
24 functionality and effectiveness.¹⁰

25
26 Non-medical factors have been found to influence decisions regarding whether a stable patient will
27 be transferred to another facility for inpatient care, but again, the impact on quality of care is
28 unknown. An analysis of all-payer administrative data from a representative sample of community
29 hospitals in the United States found that uninsured patients and women were significantly less
30 likely to be transferred to another acute care hospital.¹¹ The study authors were surprised to find the
31 lower rate of transfer for uninsured patients, expecting that a hospital would seek to transfer
32 uninsured patients as soon as they fulfilled their EMTALA obligations. Instead, the study authors
33 suspected that the lower transfer rates for uninsured patients can be explained by an unwillingness
34 of receiving hospitals to accept uninsured transfer patients. At the same time, the study authors
35 emphasized that economic factors are unlikely to explain the lower transfer rates they found for
36 women, and they expressed concern for the potential of implicit or explicit biases contributing to
37 this disparity. Critically, though, it is unknown whether the differences in transfer patterns
38 identified in this study led to differences in health outcomes.

39
40 Hospitals' interfacility transfer agreements and protocols can impact patient care not only within
41 inpatient departments, but in the ED as well. To the extent that inpatient beds are reserved for
42 specific categories of patients, including interfacility transfer patients, challenges can arise when
43 there are insufficient inpatient beds available to receive transfers from the medical center's ED.¹²
44 Patients who stay in the ED for longer than the time required for a "timely transfer" to an inpatient
45 bed are considered "boarders," and challenges surrounding boarding patients in the ED are well-
46 established.¹³ (Definitions of "timely transfer" vary, but experts often look for a period of less than
47 two hours from the admission order.) Boarding can exacerbate health disparities, with Black,
48 female, elderly, and psychiatric patients being more likely to board for longer periods of time.¹⁴
49 Moreover, patients with medically treated conditions are more likely to board than those with
50 surgically treated conditions.¹⁵ With the ED being the dominant source of hospital admissions,¹⁶ it
51 is critical for medical center transfer policies to promote optimal care for the patients who present

with emergent and/or serious conditions, both before and after their stabilization. The problems associated with patient boarding are so severe, there is evidence that they increase in-hospital death rates substantially.¹⁷ Reflecting these problems, The Joint Commission (TJC) imposes requirements that hospitals address boarding for purposes of accreditation.¹⁸ Importantly, reservation of inpatient beds for interfacility transfer patients is just one factor contributing to the complex challenge of ED boarding, and solving the broader issue of ED boarding is beyond the scope of this report.

When contemplating the transfer of a stable patient who is not receiving care in an ED, in addition to the critical clinical implications of the transfer, patient financial impacts must also be considered. Prior to transferring a patient to a new medical center, it is important to consider whether the new facility is in-network under the patient's health plan. If the intended transfer facility is out-of-network (OON), the patient and/or family will need to be prepared for the financial implications of receiving OON care. Additionally, if the patient is receiving, or intends to receive, care that requires prior authorization (PA), it is important to recognize that site of service can be an essential element of PA approval,¹⁹ so a service approved at an originating facility may require reapproval for a new site of service. Transfer decisions should include a patient-centered discussion between a patient and/or family and a referring physician that addresses the various potential merits and risks of undergoing a transfer.²⁰

The novel coronavirus (COVID-19) pandemic has posed unprecedented challenges, including managing patient transfers. Geographically localized surges in COVID-19 cases put extreme pressure on local health care facilities, as hospitals strive to transfer COVID-19 patients to sites where they can receive optimal care and/or transfer non-COVID-19 patients out of their facility to protect uninfected patients and free up resources to care for more COVID-19 patients.²¹ State and local emergency medical planners have taken a variety of approaches in rising to meet the pandemic's challenges, and the Centers for Disease Control and Prevention (CDC) has issued guidance around patient safety and relief for health care facility operations.²² The CDC emphasizes the importance of communication between health care professionals at both the transferring and receiving facilities with accurate clinical descriptions of patients and clear acceptance by receiving facilities.

Balancing the complex considerations surrounding patient transfers, the American College of Emergency Physicians (ACEP) has published guidelines on Appropriate Interfacility Patient Transfer, and AMA policy (Policies H-130.982 and H-130.961) expressly supports these guidelines. Key elements of the ACEP guidelines specify, "The medical facility's policies and procedures and/or medical staff bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital . . . Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of the transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer. When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place."²³ These guidelines, developed by subject matter experts and supported by the AMA, help to ensure that high quality patient care drives interfacility patient transfers, with physician input into the decision-making process.

EXTERNAL FACTORS SHAPING PATIENT TRANSFER POLICIES

Medical centers' ability to implement transfer policies such as the auto accept policies described in Resolution 818-I-19 is influenced by a number of external factors, including Medicare Conditions

of Participation (COPs), accreditation standards, medical staff governing documents, and in certain cases, state and/or federal law. Medicare COPs govern patient transfer in the context of discharge planning, requiring that hospitals transfer or refer patients to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.²⁴ Moreover, Medicare COPs make clear that the medical staff “is responsible for the quality of medical care provided to patients by the hospital,”²⁵ and TJC provides an accreditation framework to guide medical center and physician collaboration. As outlined by TJC, “The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.”²⁶ Additionally, for a medical center’s “governing body to effectively fulfill its accountability for the safety and quality of care, it must work collaboratively with the medical staff leaders toward that goal.”²⁷ While accreditation standards do not have the force of law, TJC’s long history of hospital accreditation and its recognition by federal and private payers have made its standards nationally accepted practices.²⁸ Additionally, medical staff documents including bylaws, rules and regulations, and policies govern the relationship between medical centers and their medical staff. The bylaws describe the rights, responsibilities, and accountabilities of the medical staff and specify how the organized medical staff works with and is accountable to the governing body. Medical staff rules and regulations usually address patient care issues across the organization and typically contain provisions about patient transfers.²⁹

As the sponsors of Resolution 818-I-19 indicate, EMTALA provides a legal framework for many interhospital transfers, with specific mandates for both facilities and physicians. EMTALA was established as federal law in 1986, and many states have related laws and regulations that impose additional duties on hospitals and physicians.³⁰ EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without minimally providing a medical screening examination to ensure the patients were stable for transfer. Additionally, under EMTALA, hospitals with specialized capabilities must accept patient transfers from hospitals that lack the capability to treat unstable emergency medical conditions, and EMTALA transfer obligations apply, even under the extraordinary circumstances posed by COVID-19.³¹ However, EMTALA does not apply to the transfer of stable patients. Importantly, both hospitals and physicians can be penalized for EMTALA violations, with penalties including termination of the hospital or physician’s Medicare provider agreement and fines of up to \$104,826 per violation.³² With both the hospital and the physician individually liable under EMTALA, it is critical that both work together to ensure that patient transfers further the shared goal of optimal patient care.

RELEVANT AMA POLICY

AMA policy directly responds to the resolves of referred Resolution 818-I-19. First, a comprehensive array of policy guides collaboration between medical centers and medical staff. Policy H-225.957 sets forth principles for strengthening the physician-hospital relationship, emphasizing the interdependence between the organized medical staff and the hospital governing body, while highlighting the medical staff’s role in quality-of-care issues. Similarly, Policy H-225.971 provides a strong framework for how hospitals and medical staff ought to collaborate and articulates the primary role of the medical staff on matters of quality of care and patient safety. In addition, Policy H-225.942 provides a set of physician and medical staff member bill of rights, which include the right to be well-informed and share in the decision-making of the health care organization’s operational and strategic planning. Finally, Policy H-225.961 states that in crafting medical staff development plans, hospitals/health systems should incorporate the principles that the medical staff and its elected leaders must be involved in the hospital/health system’s leadership function, including in developing operational plans, service design, resource allocation, and organizational policies. The policy further insists that the medical staff must ensure that quality patient care is not harmed by economic motivations.

1 Long-standing policy also guides the transfer of patients among medical centers. Policy H-130.982
2 provides principles to guide interfacility transfers of unstable emergency patients, detailing the
3 critical roles of both the transferring and receiving physicians and endorsing ACEP's Appropriate
4 Interfacility Patient Transfer guidelines. Similarly, Policy H-130.961 also endorses the ACEP
5 guidelines, encouraging county medical societies and local hospitals to review and utilize the
6 ACEP guidelines as they develop local transfer arrangements. In addition, Policy H-130.965
7 supports working with the American Hospital Association (AHA) to develop model agreements for
8 appropriate patient transfer.

9
10 Finally, AMA policy and advocacy strive to protect patients and physicians facing burdens from
11 health plan OON restrictions and PA requirements. Policy H-285.904 sets forth principles related
12 to unanticipated OON care, and Policy H-320.939 details the AMA's position on PA and
13 utilization management (UM) reform.

14
15 In addition to AMA policy, AMA ethics opinions also guide physicians and medical centers as they
16 refine patient transfer policies. *Code of Medical Ethics* Opinion 9.5.1 guides the relationship
17 between an organized medical staff and hospital and establishes that the core responsibilities of the
18 organized medical staff are the promotion of patient safety and the quality of care.³³ Additionally,
19 *Code of Medical Ethics* Opinion 9.4.2 provides a series of steps physicians should take if they
20 become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to
21 violate ethical or legal standards.³⁴

22 23 DISCUSSION

24
25 The Council thanks the sponsors of Resolution 818-I-19 for highlighting the critical intersection of
26 medical center transfer policies with quality of care, public health, legal/regulatory, and medical
27 staff concerns. Existing AMA policy lays the groundwork to protect patients and physicians in the
28 context of patient transfers, and this policy can be expanded. First, the Council recommends
29 amending Policy H-130.982, changing the title of the policy and broadening the language used, so
30 that this long-standing policy guiding the transfer of emergency patients would apply to protect all
31 transferred patients. Similarly, the Council recommends building upon the strong policy that
32 establishes a physician and medical staff member bill of rights and outlines the rights and
33 responsibilities of organized medical staff. Policy H-225.942 emphasizes the importance of
34 physicians' treatment decisions remaining insulated from commercial or other motivations that
35 could threaten high-quality patient care and the medical staff's responsibility to participate in the
36 health care organization's operational and strategic planning to safeguard the interests of patients,
37 the community, the health care organization, and the medical staff and its members. The policy
38 also outlines medical staff rights, including the right to be well-informed and share in the decision-
39 making of the health care organization's operational and strategic planning, including involvement
40 in decisions to grant exclusive contracts, or close medical staff departments. The Council
41 recommends amending Policy H-225.942 to articulate the medical staff's right to be well-informed
42 and share in the decision-making regarding transferring patients into, out of, or within the health
43 care organization. Additionally, the Council recommends amending Policy H-130.965 to support
44 working with both the AHA and other interested parties to develop model agreements for
45 appropriate patient transfer.

46
47 Finally, recognizing the significant patient, physician, and medical center time and talent involved
48 in obtaining PA approval, the Council believes that when circumstances (such as the site of
49 service) change, the PA process should support revisions to pending or existing approvals rather
50 than require re-initiation of the PA request. In articulating the AMA's position on PA and UM

reform, Policy H-320.939 emphasizes that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. Building upon this strong advocacy position, the Council recommends amending Policy H-320.939 by adding a new section four stating that health plans should minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending PA requests.

The Council also recommends reaffirming several policies that address key concerns raised by Resolution 818-I-19. Speaking to physician and medical staff roles in decision-making regarding patient transfers, Policy H-225.957 provides principles for strengthening the physician-hospital relationship. Policy H-225.957 emphasizes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff and sets forth parameters for collaboration and dispute resolution between the medical staff and hospital governing body. In addition, Policy H-225.971 details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing and reaffirms TJC standard that medical staffs have “overall responsibility for the quality of the professional services provided by individuals with clinical privileges.” Moreover, the policy states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. Reaffirming these policies underscores the AMA’s longstanding and continuing commitment to productive collaboration between physicians and medical centers in developing patient transfer practices that are focused on providing high-quality patient care. Finally, the Council recommends reaffirming Policy H-285.904, which sets forth principles to protect patients receiving unanticipated OON care. Policy H-285.904 states that patients must not be financially penalized for receiving unanticipated care from an OON provider; insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties; and patients who are seeking emergency care should be protected under the “prudent layperson” legal standard, without regard to PA or retrospective denial for services after emergency care is rendered.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

H-130.982 Interfacility Patient Transfers of Emergency Patients

Our AMA: (1) supports the following principles for ~~the interfacility patient transfers of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician’s judgment it is in the patient’s best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician

- 1 organizations to develop, in conjunction with their local hospitals, protocols and
2 interhospital transfer agreements addressing the issue of economically motivated transfers
3 of emergency patients in their communities. At a minimum, these protocols and
4 agreements should address the condition of the patients transferred, the responsibilities of
5 the transferring and accepting physicians and facilities, and the designation of appropriate
6 referral facilities. The American College of Emergency Physicians' Appropriate
7 Interfacility Patient Transfer should be reviewed in the development of such community
8 protocols and agreements; and (3) urges state medical associations to encourage and
9 provide assistance to physician organizations that are ~~their county medical societies as they~~
10 developing such protocols and interhospital agreements with their local hospitals. (Modify
11 Current HOD Policy)
12
- 13 2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as
14 follows:
15
16 d. The right to be well informed and share in the decision-making of the health care
17 organization's operational and strategic planning, including involvement in decisions to
18 grant exclusive contracts, ~~or close medical staff departments, or to transfer patients into,~~
19 out of, or within the health care organization. (Modify Current HOD Policy)
20
- 21 3. That our AMA amend Policy H-130.965 by addition as follows:
22
23 Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the
24 basis of economics; (2) supports working with the American Hospital Association (AHA)
25 and other interested parties to develop model agreements for appropriate patient transfer;
26 and (3) supports continued work by the AMA and the AHA on the problem of providing
27 adequate financing for the care of these patients transferred. (Modify Current HOD Policy)
28
- 29 4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:
30
31 4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and
32 medical centers when updates must be made to previously approved and/or pending prior
33 authorization requests. (Modify Current HOD Policy)
34
- 35 5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the
36 physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration
37 and dispute resolution between the medical staff and the hospital governing body, and it
38 establishes that the primary responsibility for the quality of care rendered and for patient
39 safety is vested with the organized medical staff. (Reaffirm HOD Policy)
40
- 41 6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and
42 hospital governing bodies and management each and collectively play in quality of care
43 and credentialing. Policy H-225.971 states that hospital administrative personnel
44 performing quality assurance and other quality activities related to patient care should
45 report to and be accountable to the medical staff committee responsible for quality
46 improvement activities. (Reaffirm HOD Policy)
47
- 48 7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to
49 unanticipated out-of-network care. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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Appendix: Policies Recommended for Amendment or Reaffirmation

H-130.965 Refusal of Appropriate Patient Transfers

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Sub. Res. 155, I-89Reaffirmed: Sunset Report and Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 01, A-20)

H-130.982 Transfer of Emergency Patients

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals.

(CMS Rep. H, A-86Reaffirmed: BOT Rep. BB, A-90Reaffirmed: CMS Rep. F, I-92Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Modified: CMS Rep. 01, A-20)

H-225.942 Physician and Medical Staff Member Bill of Rights

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can

physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

(BOT Rep. 09, A-17Modified: BOT Rep. 05, I-17Appended: Res. 715, A-18Reaffirmed: BOT Rep. 13, A-19)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self-govern, as that authority is set forth in the governing documents of the organized medical staff. The organized

medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:

- a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
- b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
- c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
- d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
- e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
- f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
- g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
- h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality-of-care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
- i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
- j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

(Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10Reaffirmation A-12Reaffirmed: CMS Rep. 6, I-13)

H-225.971 Credentialing and the Quality-of-Care

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and

credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.

(BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13)

H-285.904 Out-of-Network Care

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19

H-320.939 Prior Authorization and Utilization Management Reform

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA

research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18

Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-JUN-21

Subject: Urgent Care Centers

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Similar to retail health clinics, urgent care centers (UCC) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public's desire and expectation of prompt, available, and convenient care.¹ The Council noted that American Medical Association (AMA) policy is largely silent on UCCs and the extent UCCs should play a role in meeting the health care needs of patients.

This report, initiated by the Council, provides background on UCCs, notes the various types of ownership models, outlines the extent of physician oversight and physician employment in the centers, summarizes relevant policy, and proposes new recommendations that expand upon the current body of policy on stand-alone health care clinics.

BACKGROUND

UCCs are free-standing same-day clinics focused on caring for patients who need expedient medical care but who are not experiencing a life-threatening emergency. In 2019, there were more than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018.² They provide unscheduled, episodic care to patients. These centers usually provide services such as treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory infection.³ Additionally, the number of stand-alone care settings such as UCCs and retail health clinics continues to grow each year as patients look for and expect timely care and convenience. These settings are usually open daily, evenings, and weekends making them an attractive alternative to primary care physician offices for unplanned visits.

Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs indicates that 55 percent of their patients are covered by private health insurance and 22 percent by either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers' compensation.⁴ UCCs usually require upfront payment for services from uninsured patients creating a barrier to care for these patients.

In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act obligations to see, treat, or stabilize patients without regard for the patient's ability to pay.⁵

URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

In addition to convenience, proponents of UCCs state that the centers generate health care system cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-urgent. An additional 24 percent of visits are classified as semi-urgent.⁶ Therefore, it seems that the utility of UCCs does not lie in their ability to provide substitutive care.

UCCs also have the potential to divert patients away from their usual source of care or patients might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the patient-physician relationship. There are also worries, in an attempt to save money, insurers are encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation. Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a corresponding increase to the cost to the health care system. Accordingly, although UCCs have a role to play in the health care system, it is critical that this role is clearly defined and put into practice to avoid increased health care costs and care fragmentation.

URGENT CARE CENTER OWNERSHIP

Initially, when UCCs started to emerge in the early 2000s, they generally were opened by physicians, physician practices, and medical groups. However, more recently, the proliferation of UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008, 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital ownership grew to 37 percent in 2014. At times, because of a UCC's connection to a hospital, it is effectively treated less as a separate extension of that hospital.⁷

UCC developers and health systems have also started partnering with private equity firms and payers.⁸ For example, UnitedHealth Group (UHG) and its Optum medical care services unit purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of clinics and UCCs will increasingly be "wired together" throughout the country.⁹

PHYSICIAN OVERSIGHT

According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of facilities employing at least one full-time physician.¹⁰ Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.¹¹ Physician employment at UCCs tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.¹² Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse practitioners and physician assistants to provide the majority of care.

RELEVANT AMA POLICY

UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the

number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual, company, or other entity establishing or operating a retail health clinic must have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at retail health clinics.

[Council on Medical Service Report 7-A-17](#) further articulated AMA retail clinic policy (i.e., Policy H-160.921) by supporting that a retail health clinic must help patients who do not have a primary care physician or usual source of care to identify one in the community; must use EHRs to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent; must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; should use local physicians as medical directors or supervisors; clinics should neither expand their scope of services beyond minor acute illnesses nor expand their scope of services to include infusions or injections of biologics; and should have a well-defined and limited scope of services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include in any marketing materials the qualifications of the onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

The AMA also has established policy that addresses the patient-physician relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of every health care system should be available to the consumer (Policy H-165.985).

The AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health

professionals such as nurse practitioners and physician assistants function under the supervision of a physician (e.g., Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure, and the discretion of the physician team leader. Policy H-160.906 defines “physician-led” in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

LEGISLATIVE ACTIVITY

Early in the emergence of UCCs, state regulation largely focused on defining “urgent care,” articulating services included within the definition, and accreditation standards. More recently, as the number of UCCs has increased, states are starting to pursue a more active role in urgent care regulatory oversight. For example, some states give state health agencies the authority to license UCCs.¹³

AMA ACTIVITY

With respect to scope of practice issues, the AMA has established the Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to oppose the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

DISCUSSION

The Council believes that UCCs can play a role in meeting the health care goals of high quality, efficient care. Nonetheless, striking a patient-centered balance between the use of UCCs and traditional physician visits, including the ED, requires coordination between the various health care settings. Coordination leads to better outcomes and protects against duplicative care. The Council believes that UCCs can serve as a health care access point when a patient’s usual source of care is unavailable. Therefore, in its recommendations, the Council emphasizes that the design and use of UCCs, just like retail clinics, should serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. Accordingly, the Council recommends a set of principles to guide the use of UCCs similar to those on retail health clinics (Policy H-160.921).

The Council recommends that a UCC must help patients who do not have a primary care physician or usual source of care to identify one in the community. Given that it is critical that UCCs take responsibility for ensuring continuity of care, the Council further recommends that UCCs must transfer a patient’s medical records to his or her primary care physician or other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving provider is capable of receiving it. Additionally, the Council recommends that UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.

Moreover, it has been shown that policies that support patient-centered medical home activities in UCCs can help protect against fragmentation of care.¹⁴ Accordingly, the Council recommends that UCCs work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made. The Council also notes the importance of the patient-centered medical home (PCMH) and the fact that many physicians are expanding

hours and scheduling to provide patients with enhanced access to care. To underscore the effectiveness of PCMHs and physicians' continued commitment to provide more comprehensive access to care, the Council recommends reaffirming Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology codes, including those that already exist for off-hours services. Physicians spend a significant amount of off-hours time messaging and otherwise communicating with patients, and they should be incentivized and supported to continue doing so.

Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and recommends emphasizing the importance of physician-led care by not only reaffirming Policy D-35.985 advocating for the physician-led team, but also recommending that UCCs use local physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming Policy H-385.926 supporting physicians' choice of practice and method of earning a living.

As previously stated, UCC capabilities range significantly. As such, the Council believes it is imperative that each center have a well-defined and limited scope of clinical services, provide a list of services provided by the center, provide the qualifications of the on-site providers prior to services being rendered, the degree of physician supervision of non-physician providers, and include in any marketing materials the qualifications of the onsite health care providers. Moreover, the Council believes that a physician should not be attributed to the spending for services that a patient receives at a UCC if the physician could not reasonably control or influence that spending.

The Council believes that UCCs can serve as a convenient way for patients to receive medical care that does not require life-saving interventions. However, it is critical that patients understand the limits of UCCs and not confuse them for an ED.¹⁵ Therefore, the Council recommends that UCCs be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or as a way to describe the type of care provided. Further, the Council wholeheartedly supports patient education on the role of alternative sources of care such as UCCs. Patients should be notified if physicians are providing off-hours care and told what to do in urgent situations when their physician may be unavailable. Moreover, patients should be informed of the differences between a UCC and an ED. Additionally, the Council is interested in the volume of patient transfers to an ED after a UCC visit and will monitor this issue.

When health care is provided episodically, opportunities to develop or nurture the patient-physician relationship may be missed. Therefore, it is vital to ensure that there is care coordination between the UCC and a patient's usual source of care. Emphasizing the patient-physician relationship is critical to achieving the quadruple aim. To that end, the Council's recommendations aim to ensure that UCCs can be a modern component of patient-centered care.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy)

- 1 3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside
2 the medical home, all pertinent vaccine-related information should be transmitted to the
3 patient's primary care physician and the administrator of the vaccine should enter the
4 information into an immunization registry, when one exists. (Reaffirm HOD Policy)
5
- 6 4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of
7 services described by Current Procedural Terminology (CPT) codes, including those for
8 off-hour services. (Reaffirm HOD Policy)
9
- 10 5. That our AMA supports that any individual, company, or other entity that establishes
11 and/or operates urgent care centers (UCCs) adhere to the following principles:
12
 - 13 a. UCCs must help patients who do not have a primary care physician or usual source
14 of care to identify one in the community;
15
 - 16 b. UCCs must transfer a patient's medical records to his or her primary care
17 physician and to other health care providers, with the patient's consent, including
18 offering transfer in an electronic format if the receiving physician is capable of
19 receiving it;
20
 - 21 c. UCCs must produce patient visit summaries that are transferred to the appropriate
22 physicians and other health care providers in a meaningful format that prominently
23 highlight salient patient information;
24
 - 25 d. UCCs should work with primary care physicians and medical homes to support
26 continuity of care and ensure provisions for appropriate follow-up care are made;
27
 - 28 e. UCCs should use local physicians as medical directors or supervisors;
29
 - 30 f. UCCs should have a well-defined scope of clinical services, communicate the
31 scope of services to the patient prior to evaluation, provide a list of services
32 provided by the center, provide the qualifications of the on-site health care
33 providers prior to services being rendered, describe the degree of physician
34 supervision of any non-physician practitioners, and include in any marketing
35 materials the qualifications of the on-site health care providers; and
36
 - 37 g. UCCs should be prohibited from using the word "emergency" or "ED" in their
38 name, any of their advertisements, or to describe the type of care provided. (New
39 HOD Policy)
40
- 41 6. That our AMA work with interested stakeholders to improve attribution methods such that
42 a physician is not attributed to spending for services that a patient receives at an UCC if the
43 physician could not reasonably control or influence that spending. (New HOD Policy)
44
- 45 7. That our AMA support patient education including notifying patients if their physicians are
46 providing off-hours care, informing patients what to do in urgent situations when their
47 physician may be unavailable, informing patients of the differences between an urgent care
48 center and an emergency department, and asking for their patients to notify their physician
49 or usual source of care before seeking UCC services. (New HOD Policy)

Fiscal Note: Less than \$500

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REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)
(Reference Committee A)

EXECUTIVE SUMMARY

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council decided to initiate a report addressing equity in telehealth, believing that additional AMA policy is needed to advocate for solutions and infrastructure that facilitate equitable telehealth access. In addition, this report specifically responds to Items (a) and (c) of the second resolve of Alternate Resolution 203 that were referred and referred for decision, respectively, at the November 2020 Special Meeting of the House of Delegates.

Existing AMA policy addressing equity in telehealth recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

The Council welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the novel coronavirus pandemic. To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-JUN-21

Subject: Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council believes that additional AMA policy is needed that advocates for solutions and infrastructure that facilitate equitable telehealth access. Policy D-480.963, newly adopted at the November 2020 Special Meeting of the House of Delegates, states that our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and supports the use of telehealth to reduce health disparities and promote access to health care. This new policy provides an essential foundation upon which additional policy addressing equity in telehealth can be developed and is consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation." Furthermore, AMA's vision statement for health equity states: "The AMA's vision for health equity is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, everyone has the power to achieve optimal health, and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system."

In addition, at the November 2020 Special Meeting of the House of Delegates, four potential additions to the second resolve of Alternate Resolution 203 were referred or referred for decision. The second resolve of Alternate Resolution 203-Nov-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:

1. provide equitable coverage that allows patients to access telehealth services wherever they are located; and
2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second resolve. Items (a) and (b) were referred. Items (c) and (d) were referred for decision.

- a) promote continuity of care by preventing payers from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Items (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report specifically responds to Items (a) and (c); Council on Medical Service Report 8, also being considered at this meeting, addresses Items (b) and (d).

This report provides background on barriers to and inequities in accessing telehealth; highlights programs and pathways to augment the ability of physicians to provide telehealth to historically marginalized and minoritized communities; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

The expansion of telehealth services as a result of the novel coronavirus (COVID-19) pandemic has positively impacted patients who now have the ability to utilize telecommunication technology to access their physicians without having to navigate public transportation in densely populated urban communities, take time off from work to commute to and from the appointment, or drive lengthy distances in rural areas to attend an outpatient office visit with a specialist. In addition, telehealth provides a mechanism to overcome other barriers affecting patients' ability to access in-person services, including functional impairments that make it difficult to get to a physician's office or require a family member, friend, or caregiver to accompany the patient, and the need to find care for children or grandchildren. Importantly, the increased use of telehealth provides another pathway for physicians to learn more about the social determinants of health that may influence a patient's health and access to health care, including one's living environment, economic stability and food security.

Overall, according to a recent survey, during the first six months of the COVID-19 pandemic, one-third of adults ages 18 to 64 reported having had a telehealth visit--defined in the survey as either audio-only or two-way audio-video. Adults with multiple chronic conditions as well as those in poorer health were much more likely to report using telehealth to access care than their counterparts. Black and Hispanic adults were more likely to use telehealth than White adults, and adults living in metropolitan areas were more likely to have used telehealth than adults living outside metropolitan areas. At the same time, patients reported going without a telehealth visit despite wanting one; adults in fair or poor health, those with chronic conditions, and Hispanic adults were more likely to report going without wanted telehealth care.¹ Of the Medicare fee-for-service population, more than 9 million beneficiaries received a telehealth service during the period ranging from mid-March through mid-June of 2020. More than 20 percent of Medicare beneficiaries residing in rural areas used telehealth services during that time, with 30 percent of beneficiaries in urban areas accessing telehealth services.²

Examining outpatient visits and telehealth use in a database of 16.7 million commercially insured and Medicare Advantage enrollees, a study showed that 30.1 percent of all visits from

March 18, 2020, to June 16, 2020, were provided via telehealth. During this period, the weekly number of telehealth visits among the population studied increased to 397,977 visits per week, up from 16,540 visits per week during the period from January 1, 2020, to March 17, 2020. However, not all of these services were distributed evenly across different population groups. Notably, the percentage of total visits provided via telehealth was smallest among those ages 65 and older. In addition, health plan enrollees residing in counties with the lowest percentages of residents with incomes below the federal poverty level, and percentages of White residents had a greater proportion of total visits delivered via telehealth from March to June 2020 when compared with counties with higher percentages of these residents. In addition, a lower percentage of care was provided by telehealth in rural counties than in urban counties.³

Other studies also have reported inequitable access to telehealth services during the COVID-19 pandemic, as well as potential reliance on or preference for audio-only visits over two-way audio-video visits. For example, a cohort study of patients with appointments for primary care and specialty ambulatory telehealth visits during March through May of 2020 at a large academic health system showed that older adults, patients with limited English proficiency, Medicaid beneficiaries, and Asian patients had lower rates of telemedicine utilization. The study also found that Black, Hispanic, lower-income, female and older patients had lower rates of two-way audio-video utilization.⁴ In addition, a claims-based analysis of approximately 7 million commercially insured patients found that, in the early stages of the pandemic in March and April of 2020, zip codes with 80 percent or more residents of historically minoritized racial/ethnic communities had smaller reductions in the use of in-person office visits, and smaller increases in the use of telehealth, than zip codes with 80 percent or more White residents.⁵ CMS has estimated that of the Medicare fee-for-service beneficiaries who accessed a telehealth service in the early months of the pandemic, 30 percent used audio-only telephone technology,⁶ with other studies showing higher rates of utilization of audio-only visits among low-income patients.⁷

BARRIERS TO TELEHEALTH ACCESS FOR PATIENTS

Telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities that have been impacted disproportionately by the COVID-19 pandemic. However, far more emphasis needs to be placed on ensuring that telehealth solution functionality, content, user interface, and service access are designed in an equity-centric participatory fashion with and for historically minoritized and marginalized communities, including addressing culture, language, digital literacy ability, and broadband access. In addition to assessing how solutions are designed, it is also critical that an upstream lens is used to understand the root causes of barriers to optimal use of telehealth services within historically marginalized communities, namely systemic racism and inequitable resource allocation impacting infrastructure development and access to economic and education opportunities.

In 2019, 25 million individuals in the US did not have internet access at home, and 14 million did not have equipment capable of playing video--essential for two-way audio-video telehealth--such as a smartphone, tablet, computer or other connected device.⁸ Not all home internet services are equal; speed and bandwidth issues may continue to serve as obstacles to accessing telehealth services even for patients who have internet access at home. In addition, patients who only have a smartphone and solely rely on their phone's data plan and capacity for internet access may confront data and bandwidth challenges in accessing two-way audio-video telehealth visits.

There are, notably, racial and ethnic inequities in access to the internet, with a larger percentage of Black and Hispanic individuals not having internet access at home. Individuals residing in rural

1 areas are less likely to have access to the internet at home than those in urban areas. Age-related
 2 disparities also exist, with older individuals being less likely to have internet access at home.
 3 Significantly, Medicare and Medicaid beneficiaries make up two-thirds of those who lack internet
 4 access at home, and the uninsured make up 15 percent.⁹

5
 6 In addition, the continued use and expansion of telehealth rely on equitable design to meet the need
 7 for varying levels of patient digital literacy, and how the availability of telehealth services is
 8 communicated to patients. Individuals without access to a computer or smartphone may be left out
 9 of telehealth service offerings. Even among patients with equitable access to devices and to the
 10 internet, there remain exclusionary and suboptimal design issues requiring patients to navigate
 11 email, fill out a form online or find a website--significant barriers to participating in a two-way
 12 audio-video telehealth visit. Requiring the use of a patient portal for accessing telehealth services
 13 can serve as another barrier for patients. Furthermore, the lack of transparency and equity in the
 14 design of privacy and security policies and practices in many telehealth solutions cause hesitancy
 15 among some patients as to the safety and security of telehealth visits with their physicians.

16 17 AUGMENTING THE ABILITY OF PHYSICIANS TO PROVIDE TELEHEALTH TO 18 HISTORICALLY MARGINALIZED AND MINORITIZED POPULATIONS

19
 20 To help close the digital divide in access to telehealth services, initiatives at the state and federal
 21 levels can serve as examples of, and first steps towards, what needs to be done to address some of
 22 the upstream barriers to equity in telehealth--including ensuring affordable access to needed
 23 technology to engage in two-way audio-video telehealth and investing in broadband capacity in
 24 underserved communities. Patient access to telehealth is inextricably linked to whether and how
 25 such services are covered by their health plans, including whether they can use telehealth to access
 26 care from their regular physician. Barriers to patients accessing telehealth can be overcome by
 27 fairly and equitably financing services in formats most accessible to and appropriate for patients,
 28 including two-way audio-video and audio-only.

29 30 *Federal and State Initiatives Addressing Equity in Telehealth Service Delivery and Access*

31
 32 Increased investments in telehealth service delivery and access are essential to ensure patients can
 33 maintain needed access to health care regardless of where they are and augment the ability of
 34 physicians to provide telehealth to populations who cannot currently access telehealth services.
 35 Federal initiatives have recently been launched to assist health care providers in purchasing
 36 necessary services and equipment to provide telehealth services to underserved populations and in
 37 areas that have been disproportionately impacted by the COVID-19 pandemic. In addition, many
 38 states have leveraged available Medicaid authorities to provide technology and care coordination
 39 support to augment the ability of Medicaid beneficiaries to access telehealth services during the
 40 COVID-19 pandemic.

41 42 Connected Care Pilot

43
 44 Under the auspices of the Federal Communications Commission (FCC), the Connected Care Pilot
 45 Program is a temporary program that will provide up to \$100 million over a three-year period to
 46 defray the costs faced by selected health care providers in providing connected care services,
 47 prioritizing providing these services to low-income or veteran patients. The Connected Care Pilot
 48 will cover 85 percent of the eligible costs incurred by selected pilot programs of patient broadband
 49 internet access services, health care provider broadband data connections, other connected care
 50 information services, and certain network equipment. Provider eligibility for the Connected Care
 51 Pilot Program is limited to public and nonprofit providers, including community health and mental

health centers; local health departments; rural health clinics; skilled nursing facilities; not-for-profit hospitals; and other entities.¹⁰

COVID-19 Telehealth Program

The COVID-19 Telehealth Program was established by the FCC in response to the COVID-19 public health emergency to assist health care providers in providing connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The FCC adopted the Program in a report and order released in April 2020. Through this program, the FCC will distribute the \$200 million appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, providing immediate support to eligible health care providers--limited to public and nonprofit providers like the Connected Care Pilot--responding to the COVID-19 pandemic. The FCC has outlined the following examples under the auspices of the three main categories of eligible services related to the delivery of connected care that could be funded under the Program:

- Telecommunications Services and Broadband Connectivity Services: Voice services for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.¹¹

Emergency Broadband Benefit Program

In February 2021, the FCC formally adopted a report and order to establish the Emergency Broadband Benefit Program, a program with \$3.2 billion in federal funding aimed at providing financial assistance to qualifying households to help cover the costs of broadband and device ownership. Broadband access and device ownership are critical building blocks to enable more equitable patient access to telehealth. Under the program, eligible households can receive discounts of up to \$50 per month for broadband service, up to \$75 if the household is on Tribal lands. Eligible households will also be eligible for a one-time discount of up to \$100 for the purchase of a computer or tablet. Households eligible for assistance under the Emergency Broadband Benefit Program include those that participate in an existing low-income or pandemic relief program offered by a broadband provider; Lifeline subscribers, including those who are Medicaid beneficiaries or receive Supplemental Nutrition Assistance Program (SNAP) benefits; households with children receiving free or reduced-price school meals; Pell grant recipients; and those who have lost jobs and experienced reductions in their income in the past year.¹²

Medicaid Appendix K Waivers

Medicaid Appendix K is a stand-alone appendix that states can use during emergencies, such as the COVID-19 pandemic, to request amendment to approved 1915(c) home and community-based waivers. During the COVID-19 pandemic, states have used Medicaid Appendix K authority to provide needed technology and care coordination support to targeted beneficiaries. For example, New Mexico was approved to provide up to \$500 to select Medicaid beneficiaries who do not

1 currently have access to a computer, tablet or other device to purchase such a device to support
2 their access to telehealth, including two-way audio-video as well as needed training.¹³ Kansas was
3 approved under Medicaid Appendix K authority to provide remote monitoring technology and
4 requisite training to beneficiaries with chronic diseases.¹⁴

5
6 *Covering Telehealth Services by Patients' Physicians*

7
8 Referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020
9 Special Meeting was to "promote continuity of care by preventing payors from using cost-sharing
10 or other policies to prevent or disincentivize patients from receiving care via telehealth from the
11 physician of the patient's choice." Patient access to telehealth is inextricably linked to whether
12 telehealth services provided by their physicians--the physicians with whom they have a
13 relationship--are covered by their health plan. The AMA has been highly active on the state and
14 federal levels to ensure that health plans allow all contracted physicians to provide care via
15 telehealth, and that cost-sharing is not used to incent care from other providers. Prior to the
16 COVID-19 pandemic, many health plans established a separate network for telehealth or select
17 telehealth providers, which did not always include contracted physicians who provide in-person
18 services. As a result of the pandemic, adoption of telehealth has increased dramatically and is more
19 likely to be available from an individual's physician. AMA advocacy on the state and federal levels
20 has underscored that the pre-pandemic separation of telehealth and in-person visits can no longer
21 be justified based on low levels of adoption that no longer exist. In addition, the AMA has stressed
22 that the perpetuation of separate networks is confusing for patients and threatens continuity of care
23 and the patient-physician relationship.

24
25 For example, AMA model state legislation addressing this issue, the Telemedicine Reimbursement
26 Act, states that "each carrier offering a health plan in this state shall provide coverage for the cost
27 of health care services provided through telemedicine on the same basis and to the same extent that
28 the carrier is responsible for coverage for the provision of the same service through in-person
29 treatment or consultation. Coverage must not be limited only to services provided by select
30 corporate telemedicine providers." In addition, in an April 2020 comment letter in response to a
31 proposed rule on the Medicare Advantage program, the AMA stated that "the rapid deployment of
32 telehealth services by physicians in response to the COVID-19 pandemic is significantly changing
33 the practice of medicine in ways that are likely to last long after the pandemic. Many patients are
34 now having office visits with their regular physicians via telehealth. The AMA strongly encourages
35 MA plans to cover telehealth visits and other services, at a minimum for those on the Medicare
36 telehealth list, with their physicians. The AMA is aware that some plans contract with telehealth
37 providers and encourage their enrollees to use these other services instead of covering telehealth
38 services provided by the patients' regular physicians. Patient advocates have made it very clear that
39 what is most important to patients is for all members of the patient's health care team to be
40 involved in, and adhere to, the patient's treatment plan. This continuity of care will not be possible
41 if patients are directed to separately contracted telehealth providers even when the patients' regular
42 physicians are able to provide the services via telehealth themselves."¹⁵

43
44 In addition, AMA advocacy has underscored that the cost-sharing for services provided via
45 telehealth should not vary based on the telehealth provider. Reducing cost sharing for select
46 telehealth providers who do not also provide in-person care inappropriately steers patients away
47 from their current physicians, fragmenting the health care system and threatening patients'
48 continuity of care. Importantly, the AMA has stressed that health insurers should ensure
49 transparency in coverage and patient cost-sharing of services provided via telehealth, and health
50 care professionals should effectively communicate information about the scope of telehealth visits
51 to patients.

Ensuring Fair and Equitable Payment for Two-Way Audio-Video and Audio-Only Visits

Relevant to Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, several states enacted Executive Orders early in 2020 requiring payers to provide equivalent payment for two-way audio-video visits, and sometimes audio-only visits, as compared to in-person visits. Through the end of the COVID-19 public health emergency, CMS will continue to pay for telehealth visits equivalent to in-person office visits. In the Final Rule for the 2021 Medicare Physician Payment Schedule, CMS stated that audio-only visits, described by CPT codes 99441-99443, will not be payable after the conclusion of the COVID-19 public health emergency. CMS will allow payment, however, for brief communication technology-based services (e.g., virtual check-in), described by codes G2251 and G2252, at 2021 payment rates of \$15 and \$27 respectively.

During the COVID-19 public health emergency, two-way audio-video visits are reported with existing Current Procedural Terminology (CPT) codes for office visits. Prior to the COVID-19 public health emergency, payment for two-way audio-video telehealth visits was typically equivalent to an office visit provided in a facility setting (e.g., outpatient hospital clinic), where the physician is presumed to incur no direct costs (clinical staff, medical supplies and equipment). During the COVID-19 public health emergency, payment for two-way audio-video visits was paid equivalent to an office visit provided in a non-facility setting (e.g., physician's office). It is likely that the CPT Editorial Panel will receive an application to modernize the CPT codes describing audio-only services to address the CMS concerns and to align with the temporary G codes. After such an action, the AMA/Specialty Society RVS Update Committee would review the resources typically required to perform these services.

RELEVANT AMA POLICY

Newly adopted at the November 2020 Special Meeting of the House of Delegates, Policy D-480.963 states that our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-CoV-2; (2) will advocate that the federal government, including CMS and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Policy H-478.996 states that it is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Relevant to referred-for-decision Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy D-480.965 states our AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. Established by Council Report 7-A-14, Policy H-480.946 outlines principles to guide

the coverage and payment of telemedicine services. Regarding payment for audio-only visits, Policy H-390.889 states that our AMA supports and advocates with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; and continues to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services.

Relevant to referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy H-480.946 states that patients seeking care delivered via telemedicine must have a choice of provider; and that telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. Policy D-155.987 advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information or other plan designs that may affect patient out-of-pocket costs.

DISCUSSION

While the AMA has foundational policy pertaining to the coverage and payment for telehealth, Policy D-490.963, adopted at the November 2020 Special Meeting, serves as an essential step forward in developing policy specific to addressing equity in telehealth. The new policy, as well as Policy H-478.980, recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit. As such, the Council recommends reaffirmation of Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

In addition, it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services. The Council

welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. However, eligibility of physician practices for these programs remains quite limited, and the Council sees tremendous potential in expanding eligibility for these programs so that physicians are able to help their patients engage with and access telehealth services.

To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Policy D-480.969 provided a policy foundation in this regard, advocating for telemedicine parity laws that do not limit coverage only to services provided by select corporate telemedicine providers, relevant to the emergence of companies including Amazon expanding in the telehealth space. The Council is concerned that physicians are being prevented from, or facing barriers to, providing covered services via telehealth to their patients. In addition, cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network. Such incentives could also include creating separate cost-sharing requirements or structures for in-person care and care provided via telehealth.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. The expanded use of audio-video telehealth services during the COVID-19 pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients and those in rural and other areas with limited internet access. In addition, some patients, even those who own the technology needed for two-way real-time audio-video communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Fair and equitable payments will help ensure that patients are able to receive the right care, via the most appropriate and accessible modality, at the right time.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)
3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)

- 1 4. That our AMA encourage telehealth solution and service providers to implement design
2 functionality, content, user interface, and service access best practices with and for historically
3 minoritized and marginalized communities, including addressing culture, language, technology
4 accessibility, and digital literacy within these populations. (New HOD Policy)
5
- 6 5. That our AMA support efforts to design telehealth technology, including voice-activated
7 technology, with and for those with difficulty accessing technology, such as older adults,
8 individuals with vision impairment and individuals with disabilities. (New HOD Policy)
9
- 10 6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory
11 changes to require that payers including Medicaid programs and Medicaid managed care plans
12 cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD
13 Policy)
14
- 15 7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives
16 aimed at designing access to care via telehealth with and for historically marginalized and
17 minoritized communities, including improving physician and provider diversity, offering
18 training and technology support for equity-centered participatory design, and launching new
19 and innovative outreach campaigns to inform and educate communities about telehealth. (New
20 HOD Policy)
21
- 22 8. That our AMA support expanding physician practice eligibility for programs that assist
23 providers in purchasing necessary services and equipment in order to provide telehealth
24 services to augment the broadband infrastructure for, and increase connected device use among
25 historically marginalized, minoritized and underserved populations. (New HOD Policy)
26
- 27 9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that
28 require private insurers to cover telemedicine-provided services comparable to that of in-person
29 services, and not limit coverage only to services provided by select corporate telemedicine
30 providers. (Reaffirm HOD Policy)
31
- 32 10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care
33 via telehealth. (New HOD Policy)
34
- 35 11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or
36 require the use of telehealth or in-person care or incentivize care from a separate or preferred
37 telehealth network over the patient's current physicians. (New HOD Policy)
38
- 39 12. That our AMA advocate that payments should consider the resource costs required to provide
40 all physician visits and payments should be fair and equitable, regardless of whether the service
41 is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

Fiscal Note: Less than \$500.

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REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)
Reference Committee A

EXECUTIVE SUMMARY

This report is the Council's second on licensure and telehealth in as many years and responds to elements (b) and (d) of the second Resolve of Alternate Resolution 203 that the House of Delegates referred during its November 2020 Special Meeting. Since the Council's previous report (Council Report 1-I-19, Established Patient Relationships and Telemedicine) was presented, the coverage and payment landscape for telehealth has changed considerably in response to the novel coronavirus (COVID-19) pandemic, enabling physicians to provide uninterrupted care to patients while adhering to social distancing. The surge in virtual visits across most practices and settings has been so significant that more than three-quarters of physicians reported using telehealth in 2020, up from one quarter in 2018. The Council anticipates that most physicians who increased their use of telehealth during the public health emergency will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care.

The Council acknowledges the breadth of existing American Medical Association (AMA) licensure and telehealth policy and the organization's long history of supporting solutions that make it easier for physicians to obtain licenses to practice medicine across state lines while protecting patients and preserving state oversight of the practice of medicine. The Council continues to support the Interstate Medical Licensure Compact as an important licensure solution and recommends reaffirmation of AMA policy supportive of the Compact and reduced application and licensure fees.

This report addresses a common frustration among physicians—that, outside of the temporary licensure flexibilities put in place during the public health emergency, they are prohibited by most states from using telehealth to provide longitudinal care to existing patients who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with the Federation of State Medical Boards and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met.

The Council believes the recommendations in this report will increase physician and patient satisfaction with health care, reduce physician administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-JUN-21

Subject: Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the November 2020 Special Meeting of the House of Delegates, four potential additions to the second Resolve of Alternate Resolution 203 were referred or referred for decision. The second Resolve of Alternate Resolution 203-I-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that (1) provide equitable coverage that allows patients to access telehealth services wherever they are located; and (2) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second Resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

- a) promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Paragraphs (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report is specifically responding to Paragraphs (b) and (d); Council on Medical Service Report 7, also being considered at this meeting, is addressing Paragraphs (a) and (c).

This report provides an overview of physician licensure and telehealth, describes exceptions to licensing laws authorized by states before and during the novel coronavirus (COVID-19) pandemic, summarizes relevant AMA policy, and makes policy recommendations. For the purposes of this report, the term "telehealth" refers to digital health solutions that connect patients and clinicians through real-time audio and video technology.

BACKGROUND

In response to the spread of COVID-19, widespread stay-at-home orders, and federal and state policy changes instituted last spring, the use of telehealth by physicians and other health professionals expanded exponentially. Swift adoption of telehealth across most practices and settings enabled physicians to provide uninterrupted continuity of care while adhering to social distancing that protected patients and health professionals from exposure to the virus. The surge in telehealth is reflected in data from recent biennial AMA Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. Benchmark Survey data show a substantial increase in the use of telehealth between 2018 and 2020, with 79 percent of physicians reporting use of telehealth in their practice in 2020, up from 25 percent in 2018.¹ Additionally, last summer more than 75 percent of respondents to the Telehealth Impact Physician Survey said that telehealth enabled them to provide quality care for COVID-19-related care, acute care, chronic disease management, hospital or emergency department follow-up, care coordination, preventive care, and mental or behavioral health.² Sixty percent of physicians reported that telehealth has improved the health of their patients, while 55 percent indicated that telehealth has improved their work satisfaction.³ Payment (73 percent) and technology challenges for patients (64 percent) were cited by a majority of physicians as barriers to maintaining telehealth after the pandemic, while 18 percent of physicians cited licensure as a barrier.⁴

The Council anticipates that many physicians who increased their use of telehealth during the pandemic will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care. The AMA continues to study telehealth use to better understand the needs of patients and physicians as well as the overall impact of telehealth on care quality and patient outcomes. At the same time, the AMA engages in robust federal and state advocacy on telehealth, weighing in on a range of policy proposals including the temporary flexibilities put in place during the public health emergency as well as proposals that will shape the practice of telehealth post-pandemic.

Interstate licensure and telehealth were addressed in [Council Report 1-I-19, Established Patient Relationships and Telemedicine](#), which highlighted concerns raised by physicians that the nation's state-based licensure system has impeded growth in telehealth use by medical homes and other physician practices, including those wishing to provide telehealth services to their regular patients when those patients travel to another state. In adopting the Council's 2019 report, the House of Delegates reaffirmed long-standing AMA policy maintaining that physicians delivering telemedicine services must be licensed in the state where the patient receives services (Policies H-480.946 and H-480.969). Additionally, by adopting the recommendations in the report, the House established Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining; advocate for reduced application and state licensure(s) fees processed through the IMLC; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

Council Report 1-I-19 highlighted the rationale behind state oversight of the practice of medicine and the licensure of physicians to practice within a state's borders. State authority to protect the health, safety and general welfare of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.⁵ The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. In addition to issuing licenses, state

1 medical boards are authorized to investigate complaints and take disciplinary action against the
 2 licenses of those who violate state law. States also license a range of other health professionals,
 3 including physician assistants and nurses, and establish scope of practice parameters within the
 4 state to safeguard the practice of medicine.

5
 6 The prevailing standard for medical licensure found in the medical practice acts of each state
 7 affirms that the practice of medicine is determined to occur where the patient is located. This
 8 standard enables states to ensure that health professionals adhere to that state's laws and
 9 regulations (e.g., licensing requirements and scope of practice parameters) and to protect the public
 10 from the unprofessional and improper practice of medicine. Because the standards and scope of
 11 telehealth services should be consistent with related in-person services (consistent with Policy
 12 H-480.946), most states similarly require physicians utilizing telehealth to be licensed in all
 13 jurisdictions where patients receive care. Licensure requirements established by state medical
 14 boards may vary but, according to the Federation of State Medical Boards (FSMB), 49 state
 15 boards—as well as the medical boards of the District of Columbia, Puerto Rico, and the Virgin
 16 Islands—require physicians practicing telehealth to be licensed in the state in which the patient is
 17 located.⁶

18 19 INTERSTATE LICENSURE

20
 21 Recognizing the costs and burdens associated with obtaining physician licenses to practice
 22 medicine in multiple states, the AMA has long supported making it easier to obtain licenses to
 23 practice across state lines, and addressing the cost, time and administrative burdens while
 24 preserving the ability of states to oversee the care provided to patients within their borders.
 25 Advances in telehealth, and the potential to increase access to virtual care among people in rural
 26 and underserved communities, increasingly motivated stakeholders to seek solutions that would
 27 streamline licensure processes across state lines. Ultimately, these efforts culminated in the
 28 development of the IMLC.

29 30 *Interstate Medical Licensure Compact*

31
 32 In 2017, the IMLC became operational establishing a new expedited pathway to licensure for
 33 qualifying physicians seeking to practice in multiple states. From the beginning, the AMA strongly
 34 supported the IMLC as a means of facilitating expedited licensure while ensuring that states retain
 35 the authority to regulate the practice of medicine and protect patient welfare. The IMLC adopts the
 36 prevailing standard that the practice of medicine occurs where the patient is located at the time of
 37 the physician-patient encounter. A physician practicing under a license facilitated by the IMLC is
 38 thus bound to comply with the statutes, rules, and regulations of each state wherein he/she chooses
 39 to practice medicine.

40
 41 At the time this report was written, the IMLC was an agreement among the following 30 states, the
 42 District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho,
 43 Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi,
 44 Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South
 45 Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.⁷
 46 Compact authorizing legislation has been introduced in Missouri, New Jersey, New York, North
 47 Carolina, Ohio, Oregon, Rhode Island and Texas, with other states expected to introduce legislation
 48 during 2021 legislative sessions.⁸

49
 50 Over 17,000 licenses have been issued by IMLC,⁹ and the IMLC Commission estimates that 80
 51 percent of physicians in Compact states meet the criteria for licensure.¹⁰ However, physicians

practicing in several heavily populated states—e.g., California, Florida, Massachusetts, New York and Texas—are unable to apply for expedited licenses through the IMLC since those states have not passed authorizing legislation to join the Compact. Physicians practicing in Compact states are similarly unable to use the IMLC to obtain expedite licenses in these non-Compact states.

Costs associated with Compact licenses/renewals remain an additional barrier to increased licensing via the IMLC, since physicians who want to apply must pay an initial \$700 fee plus cover the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.¹¹ Licensing fees in Compact states range from \$75 in Alabama and Wisconsin to \$790 in Maryland, with most states charging several hundred dollars. These costs may be beyond the budgets of many physician practices—particularly small practices—that continue to face COVID-19-related financial pressures. A nationwide physician survey conducted by the AMA in July-August 2020 found that practice revenue had dropped by a third, on average, and spending on personal protective equipment (PPE) had increased 57 percent.¹² Despite an increase in telehealth use, almost 70 percent of physicians were still providing fewer total visits (in-person plus telehealth) at the time of the survey than before the pandemic.¹³

Exceptions to State Licensing Laws Pre-COVID-19

Prior to the pandemic, physicians licensed by states that had not joined the IMLC or who wanted to practice in a non-Compact state were generally required to go through that state’s traditional, often lengthy, licensure application process. Allowances for circumstances under which out-of-state physicians may practice in a state without being licensed vary by state and were predominantly limited pre-pandemic to physicians consulting with in-state physicians and physicians practicing in emergencies or responding to natural disasters. Although licensing requirements across states share many commonalities, each state has its own rules and exceptions to those rules. Colorado’s Medical Practice Act [§ 12-240-107(3)(b)], for example, uniquely permits physicians licensed and lawfully practicing medicine in another state to provide “occasional services” in Colorado, provided they do not have a regular practice in Colorado and maintain malpractice insurance.¹⁴

Some states had licensure policies specific to interstate telehealth in place before the pandemic. According to FSMB, 12 state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines, while six state boards require physicians to register if they wish to practice across states.¹⁵ Florida is an example of the latter. Despite opposition from the Florida Medical Association and other health providers, Florida enacted a law in 2019 allowing out-of-state health professionals to provide telehealth services in the state without a Florida license if they register with the state medical board.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHP) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the District of Columbia that have enacted the Act.¹⁶ Some states have enacted universal licensure recognition laws to allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.¹⁷

Physicians and other health professionals employed by the US Veterans Administration, the Indian Health Service and the US Department of Defense are generally permitted by these health systems to practice—including via telehealth—outside of the state where they are licensed. States also recognize the licenses of National Disaster Medical System physician team members. The Sports Medicine Licensure Clarity Act, passed by Congress in 2018, enabled sports medicine

professionals to provide medical care to athletes and team members while traveling with an athletic team in a state in which they are not licensed. Under this law, services provided by a sports medicine professional are deemed to have occurred in the professional's primary state of licensure. The law further extends medical professional liability insurance to cover the professional with respect to medical care provided while out of state with the team.¹⁸

Liability concerns are integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

Licensing Waivers in Response to COVID-19

COVID-19 led to a slew of federal and state temporary waivers of telehealth coverage and payment regulations intended to expand the scale and reach of telehealth, thereby meeting the increased demand for virtual medical care. Federal and state licensure requirements were also waived, enabling health care professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to seek licenses in those states. After the President and US Department of Health and Human Services Secretary declared a public health emergency in March 2020, CMS used its 1135 waiver authority to temporarily waive requirements that out-of-state physicians and other health professionals be licensed in the state where they are providing services when they are licensed in another state. Licensing requirements were waived for physicians and other health professionals participating in the Medicare, Medicaid and Children's Health Insurance Program programs and meeting the following four conditions: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state; 3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area.¹⁹

CMS' actions did not waive state or local licensure requirements, which remain in effect unless also waived. Accordingly, for a physician or other health professional to avail him- or herself of the CMS waiver under the conditions described above, the state would also have to have modified its licensure requirements. Many states did so by implementing temporary changes that to varying degrees permit physicians licensed in other states to provide medical services during the public health emergency. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with or approval by the state medical board. Some waivers were more targeted, presumably based on a state's needs, and several states established emergency temporary licensure or certification processes that out-of-state providers must go through to seek permission to practice. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state, or by physicians in contiguous states that have existing patient relationships with state residents. At the time this report was written, a few states had already rescinded their temporary licensure waivers while Idaho's Governor, via executive order, had declared that all the state's waivers, including the change allowing out-of-state physicians to provide telehealth services to Idaho residents, be made permanent. [States modifying licensure requirements for physicians in response to COVID-19](#), and [states waiving telehealth licensure requirements](#), are tracked by FSMB.

The AMA has supported the need for flexibilities to effectively respond to COVID-19 but does not currently support extending the CMS licensure waiver beyond the end of the public health emergency. To protect patients, the AMA has long advocated that physicians and other health professionals providing care via telehealth must be licensed or otherwise authorized to practice in the state where the patient is receiving care to ensure that state medical practice acts, informed consent, and scope of practice laws apply, and that the state has oversight of medical practice.

Providing telehealth services in a “secure environment”

Aside from licensure, the referred item (b) also specifies that telehealth services should be provided in a secure environment, which may be relevant to temporary changes to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. To help physicians and other health professionals quickly adopt telehealth, the Office for Civil Rights (OCR) announced early in the pandemic that it would exercise discretion in enforcing violations of HIPAA privacy and security rules for physicians and hospitals who, in good faith, utilized telemedicine platforms and applications to connect with their patients. This policy allows health professionals and patients to use technologies that may not meet all HIPAA requirements, such as Skype, FaceTime and Google Hangouts, to provide care. The AMA supported this policy because it helped physicians quickly adopt telehealth without needing to first implement contracts and security reviews that are often complex and time-consuming. However, while HIPAA compliance may seem onerous and burdensome, it is a necessary ingredient to the successful use of telehealth over the long term.

HIPAA’s requirements are intended to ensure that both health professionals and their business associates are accountable for the privacy and security of patient information, thereby fortifying the trust that is central to the patient-physician relationship. Accordingly, when the public health emergency ends, the AMA has urged OCR to not continue its enforcement discretion policy, but rather to establish a glide path to compliance with HIPAA obligations. This would mean that, if the emergency ends on September 30, rather than requiring physicians to be fully in compliance on October 1, OCR should instead allow providers to begin taking steps toward compliance (e.g., engage their vendors in discussions about business associate agreements and initiate or implement their security risk analysis of a new telehealth platform). Additionally, the AMA has advocated that OCR should ensure that physicians and other health professionals are held harmless for actions taken in good faith during the public health emergency.

RELEVANT AMA POLICY

A key safeguard included in Policy H-480.946, which was established through [Council Report 7-A-14, Coverage and Payment for Telemedicine](#), stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state’s medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. The full text of Policy H-480.946 and other relevant policies is appended.

Long-standing AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for “curbside consultations” that are provided without expectation of compensation, and in the event of emergent or urgent circumstances.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policy D-275.994 supports the IMLC.

Policies

H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and supports the Uniform Emergency Volunteer Health Practitioners Act. Policy H-275.922 encourages FSMB to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state may participate in physician volunteerism in another state.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. HIPAA is addressed by Policies H-478.997, D-190.983, and H-315.964.

AMA RESOURCES AND ADVOCACY

Consistent with AMA policy, AMA model state legislation provides a framework for a modern state medical practice act that facilitates physician adoption of telemedicine. The Telemedicine Act clarifies licensure requirements for physicians treating patients via telemedicine, ensuring that, with certain exceptions (e.g., curbside consultations, volunteer emergency medical care), physicians and other health professionals practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state's medical board. The model bill also outlines steps through which a physician can establish a relationship with a new patient via telemedicine and addresses informed consent and privacy.

The AMA has created numerous resources to help guide physician practices through the successful implementation of telehealth, including a [Telemedicine Quick Guide](#), [Telehealth Implementation Playbook](#), and [Continuing Medical Education \(CME\) modules](#) available on the AMA Ed Hub. The AMA has also developed [HIPAA privacy and security resources](#) to help walk physicians through what is needed to comply with the required HIPAA privacy and security rules. The [AMA Physician Profile Service](#) is used extensively by organizations that verify physician credentials directly (e.g., licensing boards, hospitals, group practices, managed care organizations and physician recruiters).

At the beginning of the pandemic, the AMA also made available a [COVID-19 State Policy Guidance on Telemedicine](#), which outlined AMA policy recommendations for telemedicine on a range of issues, including licensure, in response to COVID-19. As noted previously, the AMA engages in robust federal and state telehealth advocacy and routinely weighs in on a range of telehealth policy proposals related to licensure, payment, coverage, technology and equity. Federal legislation addressing licensure includes the Temporary Reciprocity to Ensure Access to Treatment Act or the TREAT Act (S 168/HR 708), which would provide nationwide temporary licensing reciprocity for telehealth and in-person care during the public health emergency and for 180 days thereafter. The AMA is neutral on this legislation because it specifies that health professionals providing care across state lines will be subject to the jurisdiction of the state in which the patient is located. The Equal Access to Care Act (S 155/HR 688) would allow health professionals in one state to provide telemedicine in states where they are not licensed during the public health emergency and for 180 days thereafter. The site of care in this legislation is considered to be the state where the health professional is located. More broadly, in response to the COVID-19 pandemic the AMA has:

- sought and secured broad telehealth coverage expansion and improved payments at the federal and state levels to increase access to care and provide patients with a safer way to receive care;
- secured introduction of legislation to make key telehealth policy changes permanent; and
- obtained permanent ability to use smart phones for Medicare telehealth services.

DISCUSSION

Once the COVID-19 pandemic was declared a public health emergency, many states quickly waived licensure requirements so that physicians licensed in one state could provide medical care—including via telehealth—to patients in another state. Scores of executive orders and regulatory actions that expanded coverage for and payment of telehealth led to a substantial surge in virtual services, enabling physicians to provide uninterrupted continuity of care amidst stay-at-home orders and helping to ease physician shortages in areas hardest hit by COVID-19. The AMA continues to hear success stories from patients and physicians who view the expansion of telehealth positively and are more comfortable with telehealth than ever before. The Council encourages continued assessment of the experiences of physicians who have used licensing flexibilities to provide telehealth across state lines as well as the impact of virtual services on care quality and patient outcomes. The Council also understands the challenges facing physician practices trying to compete with corporate telehealth entities—including those contracting with payers to provide telehealth—and how these challenges may increase post-pandemic.

The Council is mindful that physicians hold strong, divergent opinions about interstate telehealth and whether the licensure flexibilities put in place during the public health emergency should be made permanent. Some proponents want to abandon the prevailing standard that physicians must be licensed in the state where the patient is located and move toward national licensure and/or federal oversight of interstate telehealth. Other physicians prefer to uphold the state-based licensing structure—which dates to the 1800s and is embedded in state authority granted by the 10th Amendment—and continue treating the location of the patient (originating site) as the site of service. The Council continues to believe that patient safety should remain the primary consideration and that licensure of physicians and other health professionals should remain within the purview of each state. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement

1 concerns since states are generally unable to investigate incidents that happen in another state.²⁰
2 Similarly, states cannot take action against the license of a physician in another state.
3

4 Considering the differing views among physicians and the issues raised in paragraphs (b) and (d) of
5 the second Resolve of Alternate Resolution 203-Nov-20, the Council focused its deliberations on
6 helping physicians, practices and patients by allowing physicians to treat existing patients wherever
7 they are, thereby preserving those patient relationships, ensuring continuity of care, and permitting
8 specialist care for complex patients and the seriously ill. Consistent with Policy H-480.969, the
9 Council affirmed in its 2019 report that, where there is an established patient relationship, a
10 physician should be able to use telemedicine to provide quality emergent or urgent care for a
11 patient's existing condition when that patient is traveling in another state. In this report, the Council
12 suggests broadening the scope of that statement and address a frustration common among
13 physicians—that they are prohibited by most states from using telehealth to provide longitudinal
14 care to existing patients whom they have seen in the office but who may live across a state border,
15 attend college in another state, or travel for work or seasonally. The Council believes that multiple
16 pathways are available to states to facilitate interstate telehealth for continuity of care purposes,
17 including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not
18 yet proffered. Accordingly, the Council recommends that the AMA work with FSMB, state
19 medical associations and other stakeholders to encourage states to allow an out-of-state physician
20 to use telehealth to provide continuity of care to an existing patient if certain conditions are met.
21 The Council further recommends amending Policy H-480.969 by addition to codify the previous
22 recommendation in AMA telehealth licensure policy. Because Policy H-480.969 currently
23 prohibits the use of telehealth to provide medical opinions and e-consults between physicians in
24 different states, the Council recommends additional amendments by deletion to update this policy
25 to reflect current practice.
26

27 The Council believes these recommendations will increase physician and patient satisfaction with
28 health care, reduce physician licensure-related costs and administrative burdens, help sustain
29 physician practices as they continue to recover from the economic impacts of COVID-19, and
30 address the needs of individuals with disabilities or complex health conditions who lack access to
31 specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.
32 Additionally, as discussed in Council on Medical Service Report 7-JUN-21, these
33 recommendations have the potential to address long-standing health inequities among marginalized
34 and minoritized communities.
35

36 The Council is aware of efforts at the state level to streamline or otherwise facilitate interstate
37 licensure through reciprocity or other means. To ensure that our AMA can support such efforts if
38 they align with existing policy, the Council recommends continued support for state efforts to
39 expand physician licensure recognition across state lines in accordance with the standards and
40 safeguards outlined in Policy H-480.946. The Council continues to support the IMLC as an
41 important licensure solution and hopes that the states that have not joined the Compact elect to do
42 so. Accordingly, the Council recommends that Policy H-480.946 be reaffirmed. Finally, the
43 Council recommends reaffirmation of Policy H-480.946, which delineates standards and
44 safeguards that should be met for the coverage and payment of telemedicine.
45

46 RECOMMENDATIONS

47

48 The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2,
49 Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

- 1 1. That our American Medical Association (AMA) work with the Federation of State Medical
2 Boards, state medical associations and other stakeholders to encourage states to allow an out-
3 of-state physician to use telehealth to provide continuity of care to an existing patient in the
4 state without penalty if the following conditions are met:
5 a) The physician has an active license to practice medicine in a state or US territory and
6 has not been subjected to disciplinary action.
7 b) There is a pre-existing and ongoing physician-patient relationship.
8 c) The physician has had an in-person visit(s) with the patient.
9 d) The telehealth services are incident to an existing care plan or one that is being
10 modified.
11 e) The physician maintains liability coverage for telehealth services provided to patients
12 in states other than the state where the physician is licensed.
13 f) Telehealth use complies with Health Insurance Portability and Accountability Act
14 privacy and security rules. (Directive to Take Action)
15
16 2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:
17
18 The Promotion of Quality Telemedicine H-480.969
19 (1) It is the policy of the AMA that medical boards of states and territories should require a full
20 and unrestricted license in that state for the practice of telemedicine, unless there are other
21 appropriate state-based licensing methods, with no differentiation by specialty, for physicians
22 who wish to practice telemedicine in that state or territory. This license category should adhere
23 to the following principles:
24 ~~(a) application to situations where there is a telemedical transmission of individual patient data~~
25 ~~from the patient's state that results in either (i) provision of a written or otherwise documented~~
26 ~~medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient~~
27 ~~within the board's state;~~
28 ~~(ba) exemption from such a licensure requirement for traditional informal physician-to-~~
29 ~~physician consultations ("curbside consultations") that are provided without expectation of~~
30 ~~compensation;~~
31 ~~(eb) exemption from such a licensure requirement for telemedicine practiced across state lines~~
32 ~~in the event of an emergent or urgent circumstance, the definition of which for the purposes of~~
33 ~~telemedicine should show substantial deference to the judgment of the attending and consulting~~
34 ~~physicians as well as to the views of the patient; and~~
35 (c) allowances, by exemption or other means, for out-of-state physicians providing continuity
36 of care to a patient, where there is an established ongoing relationship and previous in-person
37 visits, for services incident to an ongoing care plan or one that is being modified.
38 (d) application requirements that are non-burdensome, issued in an expeditious manner, have
39 fees no higher than necessary to cover the reasonable costs of administering this process, and
40 that utilize principles of reciprocity with the licensure requirements of the state in which the
41 physician in question practices. (Modify Current AMA Policy)
42
43 3. That our AMA continue to support state efforts to expand physician licensure recognition
44 across state lines in accordance with the standards and safeguards outlined in Policy
45 H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)
46
47 4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical
48 associations to encourage states that are not part of the Interstate Medical Licensure Compact
49 to consider joining the Compact; advocate for reduced application and state licensure(s) fees
50 processed through the Interstate Medical Licensure Compact; and work with interested state

- 1 medical associations to encourage states to pass legislation enhancing patient access to and
- 2 proper regulation of telemedicine services. (Reaffirm HOD Policy)
- 3
- 4 5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that
- 5 should be met for the coverage and payment of telemedicine, including that physicians and
- 6 other health practitioners must be licensed in the state where the patient receives services, or be
- 7 providing these services as otherwise authorized by the state's medical board. (Reaffirm HOD
- 8 Policy)

Fiscal Note: Less than \$6,000

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Appendix: Relevant AMA Policy

Policy H-480.946, "Coverage of and Payment for Telemedicine"

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:

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

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.964, “Established Patient Relationships and Telemedicine”

Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, “Coverage of and Payment for Telemedicine.” (CMS Rep. 1, I-19)

Policy H-480.969, “The Promotion of Quality Telemedicine”

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state;
- (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;
- (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the

interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as “educational tools”); Policy 410.987 (which identifies practice parameters as “strategies for patient management that are designed to assist physicians in clinical decision making,” and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.969, “Insurance Coverage Parity for Telemedicine Service”

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

Policy H-480.974, “Evolving Impact of Telemedicine”

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of

Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Policy D-275.994, "Facilitating Credentialing for State Licensure"

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-JUN-21

Subject: Addressing Payment and Delivery in Rural Hospitals

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

1 Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion
2 bringing insurance coverage and health care accessibility to millions of Americans, rural
3 Americans and the health care system intended to serve them continue to face a health care crisis.
4 By most measures, the health of the residents of rural areas is significantly worse than the health of
5 those in urban areas.¹ Though the American Medical Association (AMA) has policy on stabilizing
6 and strengthening rural health, it does not have policy specifically addressing changes to payment
7 and delivery for rural providers and hospitals to address the growing rural health crisis.

8
9 This report, initiated by the Council, provides background on the unique obstacles facing rural
10 hospitals including financial challenges, the rural hospital payer mix, the costs of delivering
11 services in the rural setting, and quality measurement and risk adjustment challenges. The report
12 also details relevant AMA policy and provides recommendations to improve the rural hospital
13 payment and delivery systems.

14 15 BACKGROUND

16
17 Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average,
18 rural residents are older, sicker, and less likely to have health insurance. They stay uninsured for
19 longer and are less likely than their urban and suburban counterparts to seek preventive services.
20 Moreover, they are more likely than urban and suburban residents to encounter possibly
21 preventable deaths from heart disease, cancer, unintentional injuries, chronic lower respiratory
22 disease, and stroke. Disparities in health outcomes continue to increase for this population
23 compared to those living in urban and suburban areas. Rural residents tend to have higher rates of
24 smoking, hypertension, and obesity. They also report less physical activity and have higher rates of
25 poverty. Rural residents are also more likely to be Medicare or Medicaid beneficiaries. For
26 example, Medicare and Medicaid make up over half of rural hospitals' net revenue.^{2,3} Additionally,
27 45 percent of children in rural areas are enrolled in Medicaid or Children's Health Insurance
28 Program compared to 38 percent of children in urban areas.⁴

29
30 Those living in rural areas often must travel long distances to access the emergency department
31 (ED) and physician offices, a barrier to care that can lead to delayed or forgone care, which can
32 worsen their health status and increase the cost of care when they do receive it. They are more
33 likely than urban and suburban residents to say that access to good doctors is a major problem in
34 their community.⁵ Rural residents live an average of 10.5 miles from the nearest hospital compared
35 with 5.6 miles and 4.4 miles for those in suburban and urban areas respectively.

36
37 From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of
38 closures compared to the 3 years prior.⁶ The closure of hospitals was generally preceded by

1 financial losses caused by a combination of decreasing rural population and inadequate payments
2 from health insurers. There are more than 2,000 rural hospitals across the country, and more than
3 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of
4 closing are small rural hospitals serving isolated rural communities.

5
6 These hospitals are frequently the principal or sole source of health care in their communities,
7 including primary care as well as hospital services. The closure of these rural hospitals could cause
8 the vulnerable populations they serve to lose access to health care and worsen health disparities.⁷
9 Rural hospitals also have more difficulty attracting physicians of varying specialties, which are
10 essential to providing care to rural populations. Often, when a rural hospital closes, recruiting and
11 retaining physicians in the local community becomes increasingly difficult, and the result is
12 decreased access to care for the surrounding population.⁸ In addition, rural hospitals often serve as
13 economic anchors in their communities, providing both direct and indirect employment
14 opportunities and supporting the local economy.⁹ Rural hospitals are hubs of employment, public
15 health, and community outreach initiatives.¹⁰ Their closure puts the already vulnerable populations
16 they serve at increased risk of losing access to health care, worsening health disparities, and
17 negatively impacting the economy of the local area.¹¹

18
19 Meanwhile, the novel coronavirus (COVID-19) pandemic has highlighted the fragility of the rural
20 health system and increased the financial threat to an unstable system. All hospitals experienced
21 lower revenue due to canceled elective procedures and some routine care, while simultaneously
22 facing higher expenses due to supplies, equipment, and staff to care for COVID-19 patients. Unlike
23 large urban hospitals, small rural hospitals do not have financial reserves that they can use to cover
24 these higher costs and revenue losses. Rural patients are also more likely to experience more severe
25 impacts from COVID-19 because they are more likely to be obese and have chronic conditions
26 such as diabetes and hypertension.¹² Temporary federal assistance during the pandemic helped
27 many rural hospitals avoid closure during 2020, but the underlying financial problems may cause
28 an increase in closures after the public health emergency ends. The financial impact of the
29 pandemic on individuals living in rural areas has been significant, as many may have experienced
30 unemployment or under employment on hourly jobs with limited benefits.

31 32 IMPACT OF PAYER MIX

33
34 A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at
35 urban hospitals.¹³ While having a high proportion of Medicare patients would be viewed as
36 financially problematic at large hospitals, for many small rural hospitals, Medicare is their “best”
37 payer because Medicare explicitly pays more to cover the higher costs of care in small rural
38 hospitals.

39
40 About 75 percent of rural hospitals are classified as Critical Access Hospitals (CAHs), which
41 provides cost-based payment for services provided to Medicare beneficiaries. To be designated as a
42 CAH, a hospital must meet a set of criteria including but not limited to being located either more
43 than 35 miles from the nearest hospitals (or CAH) or more than 15 miles in areas with mountainous
44 terrain; maintain no more than 25 inpatient beds; furnish 24-hour emergency care 7 days a week;
45 and operate a psychiatric or rehabilitation unit of up to 10 beds.¹⁴ It is important to note, however,
46 that CAH payments apply only to beneficiaries with traditional Medicare, not those with private
47 Medicare Advantage (MA) plans.

48
49 Most small rural hospitals lose money on Medicaid patients, but in some states, small rural
50 hospitals also receive cost-based payments for Medicaid patients, and some states provide special
51 subsidies to offset losses on Medicaid and uninsured patients.

For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and MA plans. Many private health insurance plans pay less than the cost to deliver essential services in small rural hospitals, whereas private plan payments at most large hospitals are higher than the cost of delivering services.¹⁵ Although most hospitals lose money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on Medicaid and uninsured patients because the payments from private payers do not generate significant profits or may not even cover the costs of providing services to the privately insured patients.

COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

Low patient volume represents a persistent challenge to the financial viability of rural hospitals. There is a minimum level of cost needed to maintain the staff and equipment required to provide a particular type of service, whether it be an ED, a laboratory, or a primary care clinic. As a result, the average cost per service will be higher at a hospital that has fewer patients. In addition, the hospital will need to incur a minimum level of overhead costs that include accounting and billing, human resources, medical records, information systems, and maintenance. These costs are allocated to each hospital service line, so the fewer services the hospital offers, the higher the cost for each service.¹⁶

The mix of fixed costs paired with low volumes can result in instances where the current fee-for-service payments are often not large enough to cover the cost of delivering services in small rural communities. For example, a hospital ED must be staffed by at least one physician around the clock regardless of how many patients visit the ED. Generally, a small rural hospital will have fewer ED visits, but the standby capacity cost remains fixed, which means the average cost per visit will be higher. Therefore, a payment per visit that is high enough to cover the average cost per service at a larger hospital will fail to cover the costs of the same services at a smaller rural hospital. Exacerbating this issue is that some private plans pay small rural hospitals less than they pay larger hospitals for delivering the same services even though the cost per service at the rural hospital is intrinsically higher.¹⁷

Due to the low population density in rural areas, it is impossible for many rural hospitals to have enough patients to use the full minimum capacity of services such as an ED. Medicare explicitly pays small rural hospitals more to compensate for the higher average costs, but most other payers do not, which is why small rural hospitals have greater financial problems.

QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALS

Current quality measurement systems are problematic for small rural hospitals. Many commonly used quality measures cannot be used in small rural hospitals because there are too few patients to reliably measure performance, and some measures are not relevant at all for small rural hospitals because they do not deliver the services being measured.¹⁸

Rural hospital volume varies significantly for several reasons including the population of the community, the age and health status of the population, the availability of other primary care options, and the accessibility of the hospital. Many currently used quality measures are not applicable to numerous types of patients and aspects of care, and many focus on a specific condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size because they do not have enough patients with that specific condition. Moreover, rural hospitals

often face challenges reporting quality measurement data due to limited staff, time, and infrastructure.

The typical value-based payment system of bonuses and penalties often penalizes rural providers and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily be penalized for random variation over which they have no control.¹⁹

RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS

In addition to the reliability problems in measurement caused by small populations, the differences between rural and urban populations with respect to age, health status, and ability to access services makes risk adjustment of quality and spending measures essential. Random variation and outlier patients make risk adjustment scores less accurate at small hospitals than at hospitals with large patient populations.²⁰ The greater statistical variation at rural hospitals often leads to quality incentive payments going to higher volume hospitals that can achieve lower standard deviations but are not necessarily delivering higher quality care.

Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments to CAHs do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported by rural hospitals.²¹ Also, the use of diagnosis codes can fail to capture risk appropriately including the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health care setting and lack of support services in the community. As a result, rural hospitals and clinics can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can also make spending in rural communities appear higher than it is. For example, MA risk adjustment scores fail to accurately measure the true differences in patient health because the hierarchical condition category coding used in MA payments are retrospective based on past chronic conditions, not acute or new chronic conditions. Therefore, there is no risk adjustment for patients with injuries, acute conditions, or those newly diagnosed with cancer or diabetes, among other conditions. Likewise, the higher barriers for rural patients to obtain preventive care can cause a more severe presentation of diseases once finally diagnosed, requiring higher costs of care and poorer absolute outcomes.

RELEVANT AMA POLICY

The AMA has significant policy on rural health. Policy H-465.994 supports the AMA's continued and intensified efforts to develop and implement proposals for improving rural health care. AMA policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for health system reform should include sufficient and continuing financial support for rural hospitals. Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities. Policy D-465.999 calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated CAH "necessary provider" designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Policy H-385.913 discusses payment and delivery reform in the context of the shift away from volume to value. The policy states that alternative payment models (APMs) must provide flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for

1 APMs to be feasible for physicians in every specialty and for practices of every size to participate
2 in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and
3 implementation of APMs that provide services to improve the health of vulnerable and high-risk
4 populations, including those in rural areas.

5
6 Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid
7 payments. Policy H-290.976 advocates that Medicaid payments to medical providers be at least
8 100 percent of Medicare payment rates. Policy H-290.997 promotes greater equity in the
9 Medicaid program through adequate payment rates that assure broad access to care. Further,
10 Policy D-290.979 supports state efforts to expand Medicaid eligibility as authorized by the ACA.

11 12 DISCUSSION

13
14 Long-term solutions are needed to effectively address the health needs of the rural population.
15 Preventing the closure of rural hospitals that provide essential services is a first step. Rural
16 hospitals must be paid adequately to support the costs of delivering essential services, and they
17 should have the flexibility to tailor available services to the needs of their local populations.

18
19 To begin accomplishing its goal of providing adequate payment for rural hospital services, the
20 Council recommends reaffirming Policy D-290.979 directing our AMA to support state efforts to
21 expand Medicaid eligibility, and reaffirming Policy H-290.976 stating that Medicaid payments be
22 at least 100 percent of Medicare payment rates. Medicaid eligibility and enrollment are evidence-
23 based factors strengthening the viability of rural hospitals. Medicaid expansion, particularly if it is
24 accompanied by adequate payments, will improve hospital financial performance and
25 sustainability, and lower the likelihood of closure, especially in those rural markets with large
26 numbers of uninsured patients. For example, since 2010, of the eight states with the highest levels
27 of rural hospital closures, none are Medicaid expansion states. A key cause of financial losses at
28 most rural hospitals is the volume of care provided to uninsured patients, so a key component of
29 any strategy for sustaining rural health care services is increasing the number of insured residents.

30
31 The Council identified the need for better and more reliable payment for rural hospitals that support
32 their sustainability and recommends that a series of policies be adopted to ensure that payment to
33 rural hospitals is adequate and appropriate. Since small rural hospitals need to sustain essential
34 services even with low volumes of services, the Council recommends that health insurance plans
35 provide such hospitals with a capacity payment to support the minimum fixed costs of essential
36 services, including surge capacity, acknowledging that a small rural hospital requires a baseline of
37 staffing and expenses to remain open regardless of volume. It is also recommended that payers
38 provide adequate service-based payments to cover the costs of services delivered in small
39 communities. The Council also recommends that the capacity payment provide adequate support
40 for physician standby and on-call time to enable very small rural hospitals to deliver quality
41 services in a timely manner. Regarding quality measurement, the Council recommends only using
42 quality measures that are relevant for rural hospitals and setting minimum volume thresholds for
43 measures to ensure statistical reliability and avoiding financial penalties that might occur from
44 failing to have met specific quality metrics due to lower volumes. To help effect these changes, the
45 Council recommends encouraging employers and rural residents to choose health plans that
46 adequately and appropriately pay the rural hospitals.

47
48 The Council notes that taking these steps to ensure adequate and reliable payment for rural
49 hospitals is critical to addressing the barriers to procedural service lines. A small patient population
50 and declining revenue stifles the ability of rural hospitals to add new service lines that not only
51 attract needed specialists to underserved areas but also aid in the financial sustainability of a rural

hospital. The Council believes that addressing payment issues for rural hospitals will help give those hospitals the flexibility to offer more complex services. In turn, those services will boost financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access to care.

The Council also reiterates the need to address payment for primary care services at rural facilities. The Council recommends voluntary monthly payments for primary care providers so that physicians have the flexibility to deliver services in the most effective manner, particularly for those patients for whom travel is a significant barrier to care. Importantly, such monthly payments should include an allowance and expectation that some services would be provided via telehealth or telephone.

Additionally, the Council recommends policy that encourages transparency among rural hospitals regarding their costs and quality outcomes. It will be essential that rural hospitals publicly demonstrate that higher payments are needed to support the cost of delivering high quality care.

The challenges facing the rural health system are varied and complex. Although many steps are needed to ensure access to care and quality outcomes for the rural population, the Council offers these recommendations as a pragmatic step forward to address the needs of rural populations.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
 - c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
 - f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)
4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)

- 1 5. That our AMA support better coordination of care between rural hospitals and networks of
2 providers where services are not able to be appropriately provided at a particular rural
3 hospital. (New HOD Policy)
4
- 5 6. That our AMA encourage employers and rural residents to choose health plans that
6 adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

Fiscal Note: Less than \$500.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-JUN-21

Subject: Council on Science and Public Health Sunset Review of 2011 House Policies

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association policies to ensure that our AMA’s policy database is current,
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and
4 specifying the needed procedures:
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10
10 years.
11
 - 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be
15 assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
16 asked to review policies shall develop and submit a report to the House of Delegates identifying
17 policies that are scheduled to sunset; (d) For each policy under review, the reviewing council
18 can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii)
19 retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For
20 each recommendation that it makes to retain a policy in any fashion, the reviewing council shall
21 provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the
22 House of Delegates to handle the sunset reports.
23
 - 24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
25 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy,
26 or has been accomplished.
27
 - 28 4. The AMA councils and the House of Delegates should conform to the following guidelines for
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
32 House of Delegates Reference Manual: Procedures, Policies and Practices.
33
 - 34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
35
 - 36 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Council on Science and Public Health recommends that the House of Delegates policies listed
4 in the appendix to this report be acted upon in the manner indicated and the remainder of this report
5 be filed. (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-100.977	Pharmaceutical Quality Control for Foreign Medications	Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. Citation: Res. 508, A-08;	Retain; still relevant
D-100.978	FDA Drug Safety Policies	Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. Citation: Sub. Res. 505, A-08;	Retain; still relevant.
D-115.989	Consumer Friendly Medication Identification	Our AMA: 1) strongly recommends to drug manufacturers worldwide that they put a consumer-friendly, unique identifier on the solid dosage form itself; and 2) recommends to the publishers of comprehensive lists of medications (such as PDR, Epocrates) that they include in their publications a list of these abbreviations. Citation: Res. 519, A-11;	Retain; still relevant.
D-120.952	Measuring Medication Dosages	Our AMA supports the development of guidelines to eliminate medication dosing inconsistencies. Citation: Res. 505, A-11;	Retain; remains relevant and in alignment with AMA's work as a founding member of the National Coordinating Council for Medication Error Prevention (NCCMERP).
D-120.984	Streamlining the Process for Prescription Refills	Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. Citation: (Sub Res. 522, A-03; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
D-135.979	Prevalence of Nickel Sensitization in the USA	Our AMA: 1) ~~recognizes~~ encourages appropriate federal agencies to issue an advisory on the growing prevalence of nickel sensitization, and need to promote measures which protect patients, consumers, and workers from the health risks of nickel sensitization; and 2) encourages the appropriate organization ~~Consumer Product Safety Commission~~ to issue guidelines a directive limiting maximum allowable release of nickel from products with prolonged skin contact.	Retain in part as amended; change to H-policy. The Nickel Institute has developed myriad resources about nickel, safe use, risks, and sensitization and the issue is well-

		Citation: (Res. 522, A-11)	documented in literature. However, no organization has issued guidelines for maximum allowable nickel release.
D-135.989	NAAQS Standard for Ozone	1. Our AMA ~~will sign on or endorse comments submitted by the ATS and American Lung Association~~ supporting a tightening of the NAAQS for ozone to include an ozone NAAQS of 0.060 ppm for the 8-hour standard. 2. Our AMA ~~will submit comments to President Obama expressing opposition to his decision to delay updating the EPA ozone standard and send a letter to President Obama noting that delayed setting and enforcement of a stricter ozone standard will result in more adverse health effects including asthma and COPD exacerbations, emergency room visits, hospitalizations and death.~~ Citation: (BOT Action in response to referred for decision Res. 416, A-07 and Res. 438, A-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation I-09; Appended: Res. 929, I-11)	Retain in part as amended; change to H-policy. On October 1, 2015, EPA strengthened the ground-level ozone standard to 0.070 ppm (from 0.075 ppm), averaged over an 8-hour period.
D-150.977	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	Our AMA: 1) will work with appropriate agencies, organizations, and corporations to educate health professionals and the public about healthy food choices in fast food restaurants; and 2) supports personal and parental responsibility to encourage healthy childhood behaviors, including the consumption of healthy food. Citation: (Sub. Res. 402, A-11)	Retain; still relevant.
D-20.988	HIV Education in Minority Populations	Our AMA will: 1) increase its efforts to educate minority populations regarding the risk of HIV infection across all age groups, socioeconomic class, and sexual orientation thereby preventing the spread of infection, increase early testing, and decrease the spread of this epidemic; and 2) partner with public and private organizations dedicated to public health education and preventive medicine to decrease the incidence of HIV infection and increase early intervention efforts. Citation: (Res. 405, A-11)	Retain; still relevant.
D-20.995	Universal, Routine Screening of Pregnant Women for HIV Infection	Our AMA will support the recommendations of the Institute of Medicine's report on perinatal HIV transmission, "Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States." Citation: (CSA Rep. 1, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Addressed by Policy H-20.918 , "Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission"
D-30.998	Prevention of Repeat Driving Under the Influence (DUI) Offenses: The	Our AMA encourages: (1) physicians and their state medical societies to work to create statutes that are designed to treat patients, protect the community and families, and grant immunity to physicians for good faith reporting of drug or	Retain; still relevant.

	Issues of Diversion and Treatment and Vehicle Incapacitation	alcohol impaired drivers for both permitted or mandated reporting; and (2) further research into and professional discussion about the issues of reporting medical information that could result in punishment or criminal prosecution. Citation: (BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
D-425.996	Implementing the Guidelines to Community Preventive Services	Our AMA will : (1) commend the Centers for Disease Control and Prevention (CDC) and the Task Force on Community Preventive Services for their work in developing the Guides to Community Preventive Services; (2) review the recommendations and conclusions of the Task Force on Community Preventive Services and recommend to the House of Delegates the appropriate actions as per AMA policy; ~~(3) express to the Director of CDC AMA's interest in having a liaison and alternate on the Task Force on Community Preventive Services; and~~ (4) promote the visibility of the recommendations of the Guides to Community Preventive Services as they become available, provided those recommendations comport with AMA policies and standards. Citation: (CSA Rep. 6, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part. The AMA is engaged with the Community Preventive Services Task Force and has a primary and alternate liaison.
D-440.956	Expanding the Vaccines for Children Program	Our AMA will work with its immunization partners to examine methods to improve financing mechanisms for vaccines, including the expansion of the Vaccine for Children program. Citation: (Res. 534, A-06; Reaffirmation A-07; Reaffirmation I-10; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain; still relevant.
D-490.976	Tobacco Settlement Fund	Our AMA supports state and local medical societies in their efforts to formally request that local and state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state's Tobacco Settlement Fund award annually to smoking cessation and health care related programs, and encourages society members and the public to demand this of their elected officials. Citation: (Res. 431, A-07; Reaffirmation I-11)	Rescind. Covered by H-495.983 , "Tobacco Litigation Settlements," which reads: Our AMA:(1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and

			for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco

			companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)
D-490.978	Tobacco Usage	Our AMA will: (1) advocate for the use of the tobacco settlement funds for informational public service campaigns related to smoking cessation, especially as related to young people; and (2) send a formal letter to the appropriate authority in each state and territory that was party to the tobacco settlement for an accounting of past and projected future expenditures related to smoking cessation, especially as related to young people. Citation: (Res. 408, A-06; Reaffirmation I-11)	Rescind. Covered by H-495.983 , "Tobacco Litigation Settlements" (see above)
D-490.984	AMA Opposition to Securitization of Tobacco Settlement Payments	Our AMA will work in concert with state medical societies to protect the settlement funds, including issuing statements condemning the use of settlement funds as a way to remedy state budget crises. Citation: (BOT Rep. 3, I-03; Reaffirmation I-11)	Retain; still relevant.
D-490.997	Continued Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services	Our AMA will: (1) translate that commitment into action through aggressive lobbying activities to encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force, when needed, that includes experts in public health, smoking cessation and tobacco prevention programs to ensure that funds are spent on activities supported by the Centers for Disease Control and Prevention guidelines. Citation: (Res. 428, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation I-11)	Rescind. Covered by H-495.983 , "Tobacco Litigation Settlements" (see above)
D-60.994	Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles	Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse. Citation: (Res. 401, A-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
D-95.979	Banning Synthetic Drugs Referred to as "Bath Salts"	Our AMA supports national legislation banning synthetic drugs referred to as "bath salts," containing methylenedioxypyrovalerone (MDPV), mephedrone, and related substances. Citation: (Res. 507, A-11; Reaffirmation I-11)	Rescind. Remains relevant, but because bath salts are new psychoactive substances, the issue is addressed in Policy H-95.940 , "Addressing Emerging Trends in Illicit Drug Use,"

			which reads: Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4)

			encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.
H-10.983	Swimming Safety	Our AMA (1) strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs and (2) encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety. Citation: (Res. 72, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-10.984	Farm-Related Injuries	Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries; (2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities; (3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement; (4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of	Retain; still relevant.

		agricultural injuries and about approaches to their prevention; (5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and (6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. Citation: (BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-115.968	Decreasing Epinephrine Auto-Injector Accidents and Misuse	Our AMA: 1) encourages physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and 2) encourages improved product design and labeling of epinephrine auto-injectors. Citation: (Res. 513, A-11)	Retain; still relevant.
H-115.969	Consumer Medication Information	Our AMA supports the following basic principles for supplying written prescription drug information to patients: That (1) our AMA supports the pursuit of a single document for the provision of written consumer medication information (CMI), replacing the current framework of patient package inserts, pharmacy generated prescription drug leaflets, and Medication Guides; (2) the FDA collaboratively develop, test, and implement a single-document CMI process based on rigorously defined, essential information needed by patients to safely and effectively use medications; (3) the FDA validate CMI prototypes in actual use studies; (4) CMI should be provided in electronic formats on a publicly accessible Web site so that prescribers have access to these tools for improving patient adherence; and (5) CMI should stand on its own and not be an integral component of pharmacy marketing activities. Citation: (CSAPH Rep. 3, A-11)	Retain; still relevant.
H-115.979	Policy to Reduce Waste from Pharmaceutical Sample Packaging	Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy. Citation: (Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-115.984	Product Identification of Solid Dosage Forms	Our AMA supports working with the appropriate organizations to: (1) develop a coding system for the identification of all solid medication forms; (2) encourage imprinting each tablet, capsule or other solid dosage form of a prescription drug with its unique code and the name or other distinctive mark	Rescind. CFR Title 21, Volume 4 requires that “a code imprint that, in conjunction with the product's size, shape,

		identifying the manufacturer; and (3) encourage compilation of this coding system into a reference and disseminate it to physicians, pharmacists and law enforcement agencies in an appropriate manner. Citation: (Res. 44, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 519, A-11)	and color, permits the unique identification of the drug product and the manufacturer or distributor of the product.” Many compilations of the coding system exist on the Internet, free to access.
H-120.940	Mail Order Pharmacies and Interface with Current Pharmacy Hubs	Our AMA will: (1) work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians; and (2) advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems. Citation: (Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.967	Dispensing of Computer-Generated Drug Information	1. Our AMA continues to cooperate with the National Council on Patient Information and Education (NCPIE), USP, the FDA and others to establish standards for patient information. ~~2. Our AMA continues to participate on the NCPIE to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE.~~ ~~3. Our AMA will monitor the ongoing re-evaluation of how consumer medication information is designed and provided in the US and provide input to ensure that such documents are clinically useful, written at the appropriate literacy level, and promote patient adherence.~~ Citation: (Res. 512, A-95; Appended: Sub. Res. 508, A-10; Reaffirmed: CSAPH Rep. 3, A-11)	Retain in part. AMA is no longer a member of NCPIE, as they merged with a new organization and are funded, in part, by pharmaceutical companies.
H-120.987	American Pharmacists Association	The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled. Citation: (Res. 147, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.989	Mail Service Pharmacy	The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the	Retain; still relevant.

		United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs. Citation: (BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11)	
H-130.956	Screening for Alcohol and Other Drug Use in Trauma Patients	Our AMA (1) encourages hospital medical staffs to promote the performance of blood alcohol concentration (BAC) tests and urine drug screens on hospitalized trauma patients; and (2) urges physicians responsible for the care of hospitalized trauma patients to implement appropriate evaluation and treatment when there is a positive BAC, other positive drug screen result, or other source of suspicion of a potential substance misuse or substance use disorder. Citation: (BOT Rep. J, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant
H-130.987	Emergency Medical Identification Aids	Our AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying	Retain; still relevant.

		family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; (4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) recognizes the need for patients to have the option to enroll in portable medical identification alert systems that current technologies support, such as virtual medical identification alert systems and smart cards which can offer emergency responders immediate access to pertinent health information and family contact information. Citation: (BOT Rep. U, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed by CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 815, I-11)	
H-135.933	Bisphenol A	Our AMA: 1) supports a ~~shift to a more~~ robust, science-based, and transparent federal regulatory framework for oversight of bisphenol A (BPA); ~~and 2) encourages ongoing industry actions to stop producing BPA-containing baby bottles and infant feeding cups, support bans on the sale of such products, and urge the development and use of safe, nonharmful alternatives to BPA for the linings of infant formula cans and other food can linings; and 3) recognizes BPA as an endocrine-disrupting agent and urges that BPA-containing products with the potential to increase human exposure to BPA be clearly identified.~~ Citation: (CSAPH Rep. 5, A-11)	Retain in part. In July 2012, FDA amended its regulations to no longer provide for the use of BPA-based resins in baby bottles, sippy cups, and packaging coatings for infant formula because these specified uses have been permanently and completely abandoned.
H-135.947	Guidance for Worldwide Conservation of Potable Water	Our AMA favors scientific and cultural development of a plan for worldwide potable water conservation, especially in countries affected by natural disasters or other events that disrupt the potable water supply. Citation: (Res. 406, A-04; Modified in lieu of Res. 906, I-11)	Retain; still relevant.
H-135.950	Support the Health Based Provisions of the Clean Air Act	Our AMA ~~(1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.~~ Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)	Retain in part. The New Source Review (NSR) program is complex, has a long history of rulemakings, guidance, applicability determinations and litigation that have NSR applicability. Given the many changes over the years, it is not clear what specifically this policy supports.

H-135.963	Recyclable and Reusable Utensils	Our AMA makes a commitment to use only reusable and recyclable utensils to the extent possible and encourages its constituent societies to do likewise. Citation: (Res. 608, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-135.966	Low-Level Radioactive Wastes	Our AMA (1) reiterates its endorsement of the process now in place for dealing with the disposal of low-level radioactive wastes, which involves the formation of compacts among the 50 states and the construction of regional facilities, and (2) encourages physicians to support and assist state agencies and others responsible for planning the safe disposal of low-level radioactive wastes. Citation: (BOT Rep. O, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by H-135.989 , "Low Level Radioactive Waste Disposal," which reads: "The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border; and (2) urges Environmental Protection Agency action to ensure capacity for disposal of low-level radioactive waste.
H-135.992	Acid Precipitation	Our AMA encourages further scientific studies to determine the effects of acid precipitation on the population of the U.S. and Canada in order that the maximum impact of health professionals may be brought to bear toward the solution of this problem. Citation: (Res. 66, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-145.989	Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns	It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns. Citation: (Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.962	Air Bags and Preventing Crash Injuries	Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries; (2) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and	Retain; still relevant.

		(3) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children. Citation: (BOT Rep. H, I-92; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11)	
H-15.967	Injuries Resulting from Pickup Trucks	Our AMA supports prohibiting any person from riding in the back of a pickup truck without the use of appropriate restraint devices and protection when the pickup truck is traveling on public roads. Citation: (Sub. Res. 15, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Rescind; superseded by Policy H-15.961 , "Safety for Passengers in the Back of Pickup Trucks," which states that the AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.
H-15.968	School Bus Safety and Braking and Steering Systems	Our AMA encourages (1) manufacturers of school buses to exceed the braking and steering system requirements of the U.S. Department of Transportation, making these systems as safe and easy to use as possible; (2) school bus manufacturers and federal agencies to continue their efforts to improve the safety of school buses and of school bus transportation programs, including driver education programs; and (3) physicians with an interest in children's problems, primary and secondary school education programs, or public health to evaluate pupil transportation systems in their own communities. Citation: (BOT Rep. N, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.992	Motor Vehicle Accidents	Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures. Citation: (BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.993	Child Passenger Safety	Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in	Retain; still relevant.

		motor vehicles with appropriate restraining systems. Citation: (Res. 27, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation and Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-150.934	Competitive Eating	Our AMA recognizes competitive speed eating as an unhealthy eating practice with potential adverse consequences. Citation: (Res. 418, A-11)	Retain; still relevant.
H-150.967	Food Safety - Federal Inspection Programs	Our AMA encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety. Citation: (CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.969	Commercial Weight-Loss Systems and Programs	It is the policy of the AMA to (1) continue to cooperate with appropriate state and/or federal agencies in their investigation and regulation of weight-loss systems and programs that are engaged in the illegal practice of medicine and/or that pose a health hazard to persons to whom they sell their services; (2) continue to provide scientific information to physicians and the public to assist them in evaluating weight-reduction practices and/or programs; and (3) encourage review of hospital-based weight-loss programs by medical staff. Citation: (CSA Rep. A, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.990	Sodium in Processed Foods	Our AMA (1) encourages physicians to reinforce the profession's public education programs when counseling their patients; and (2) supports the efforts of food industries to achieve useful reductions in the sodium content of processed food, without compromising their safety or nutritive values. Citation: (CSA Rep. G, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929 , "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake," which states: Our AMA will: (1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and

			reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels. (2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake. (3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
H-150.997	Excess Sodium in the Diet	Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. Citation: (Sub. Res. 22, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929, “Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake” (see above)
H-160.963	Community-Based Treatment Centers	Our AMA supports the use of community-based treatment centers for substance abuse disorders, ~~emotional~~ mental health disorders and developmental disabilities. Citation: (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.

H-170.992	Alcohol and Drug Abuse Use and Addiction Education	Our AMA: (1) supports continued encouragement for increased educational programs relating to use of and ~~addiction involving abuse of~~ alcohol, ~~cannabis marijuana~~ and controlled substances; (2) supports the implementation of alcohol and ~~marijuana~~ <u>cannabis</u> education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol, <u>cannabis products, and controlled substances</u> . Citation: (Sub. Res. 63, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation and Reaffirmed: Sunset Report, I-00; Appended: Res. 415, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.
H-175.998	Evaluation of Iridology	Our AMA believes that iridology, the study of the iris of the human eye, has not yet been established as having any merit as a diagnostic technique. Citation: (CSA Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-185.969	Insurance Coverage for Immunizations	Our AMA endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles. Citation: (Res. 430, A-97; Reaffirmation A-01; Reaffirmation A-08; Reaffirmation A-11)	Retain, still relevant.
H-210.995	Home Health Care	The AMA (1) supports the concept of home health care as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan; and (2) believes that home health care is an effective benefit to many patients. Citation: (BOT Rep. HH, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmation A-11)\	Retain, still relevant.
H-30.960	Physician Ingestion of Alcohol and Patient Care	Our AMA, believing that the possibility, or even the perception, of any alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician, (1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect. Citation: (BOT Rep. Y, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain, still relevant.
H-30.961	Student Life Styles	Our AMA (1) supports educational programs for students that deal with ~~the problem of~~ alcoholism and drugs, and (2) encourages educational institutions to continue or institute efforts to eliminate the illegal and inappropriate use of	Retain in part to eliminate stigmatizing phrasing. Remains relevant.

		alcohol and other drugs on their premises or at their functions. Citation: (Res. 159, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-345.996	Physicians, Psychotherapy and Mental Health Care	Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public. Citation: (Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain, still relevant.
H-370.989	State Regulation and Licensing of Human Tissue Banks	Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements. Citation: (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, superseded by Policy H-370.988 , "Regulation of Tissue Banking," which states: Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued

			involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues.
H-420.955	Nutrition Counseling for Pregnant and Recent Post-Partum Patients	Our AMA: 1) supports physician referrals of pregnant and post-partum patients for nutrition counseling, and 2) will advocate for the extension of health insurance coverage for nutrition counseling for all pregnant and recent post-partum patients. Citation: (Res. 409, A-11)	Retain; still relevant.
H-420.964	Fetal Alcohol Syndrome Educational Program	Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. Citation: (Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-420.965	Carrier Screening for Cystic Fibrosis	Our AMA: (1) supports the concept that participation in pilot studies or in any subsequent population screening program <u>for cystic fibrosis (CF)</u> be on a voluntary basis, with informed consent for all who wish to be tested; (2) encourages physicians to become more knowledgeable regarding genetic tests such as the one for CF, the interpretation of these tests, and genetic counseling; and (3) encourages physicians to become involved in educating the public about the nature of carrier screening for CF. Citation: (CSA Rep. C, A-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. Citation: (Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 227, A-11)	Retain, still relevant.
H-420.992	Genetic Counseling and Prevention of Birth Defects	Our AMA believes that: (1) Adequate genetic counseling must be incorporated into any prenatal screening program established for the detection of birth defects and should be available both before and after the test is performed. (2) States should enhance their laboratory capability through broader utilization of those laboratories performing genetic screening, ~~perhaps through regionalization of facilities so that karyotyping of amniotic fluid cell cultures and their biochemical analysis can be more widely available.~~	Retain as amended for clarity.

		(3) Specialty societies should enhance their efforts to train physicians in the newer techniques of ante-natal diagnosis. ~~(4) Although the case for widespread carrier screening for common heterozygous abnormalities is far from established, pilot studies should be encouraged which will explore the cost-effective level of pre-natal testing in each locality.~~ Citation: (CSA Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-440.882	Secure National Vaccine Policy	Our AMA advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk. Citation: (Res. 709, I-04; Reaffirmation A-05; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain, still relevant.
H-440.891	Support of ~~a~~ the <u>National Laboratory Response Network</u>	Our AMA supports ~~the efforts of the Centers for Disease Control and Prevention's in establishing a~~ national <u>Laboratory Response Network</u> for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns. Citation: (Res. 516, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-440.894	Support of Four Principles of Hand Awareness	Our AMA: (1) endorses the Four Principles of Hand Awareness: (a) Wash your hands when they are dirty and before eating, (b) Do not cough into your hands, (c) Do not sneeze into your hands, and (d) Above all, do not put your fingers into your eyes, nose or mouth; and (2) encourages physicians to "adopt a school" in their communities and promote the Four Principles of Hand Awareness. Citation: (Res. 404, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.950	Premarital Testing	Our AMA encourages individual states to review and reassess the need for mandatory premarital testing for infectious diseases for their respective populations and to determine whether there is a favorable cost/benefit ratio for the specific disease in question. In the absence of a favorable ratio, states should consider abandoning mandatory premarital testing for an infectious disease. Citation: (BOT Rep. Z, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.972	Water Fluoridation	Our AMA: (1) urges state health departments to consider the value of requiring statewide fluoridation (preferably a comprehensive program of fluoridation of all public water supplies, where these are fluoride deficient), and to initiate such action as deemed appropriate; and (2) supports the 2011 proposed fluoridation standards as	Retain; still relevant.

		promulgated by the US Department of Health and Human Services and the Environmental Protection Agency. Citation: (Sub. Res. 9, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res 406, A-11)	
H-440.989	Continuation of the Commissioned Corps	Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service. Citation: (Res. 5, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-455.988	Public Education on the Danger of Radiation Exposure	~~1. Our AMA encourages the appropriate federal agency to develop a nationwide public education program on the effects of radiation exposure.~~ 2. Our AMA supports public initiatives, such as the "Image Wisely" and "Image Gently" campaigns, which aim to increase awareness of radiation in the medical setting and reduce exposure. Citation: (Res. 121, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 921, I-11)\	Retain in part. The Health Resources and Services Administration (HRSA) developed the Radiation Exposure Screening & Education Program (RESEP).
H-455.993	Treatment of Radiation Accident Victims	Our AMA (1) encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located; and (2) supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. Citation: (Res. 36, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-460.907	Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients	Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. Citation: (Res. 512, A-11)	Retain; still relevant.
H-470.985	Goalie Face Masks in Hockey	Our AMA endorses the mandatory use of an adequate cage-type face mask for goalies in all amateur, high school and college hockey programs in the nation. Citation: (Res. 4, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.

H-470.986	Helmets for Hockey Referees	Our AMA endorses the use of hockey helmets for all referees in amateur, high school and college hockey programs in the US. Citation: (Res. 123, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-470.991	Promotion of Exercise	1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. Citation: (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)	Retain; still relevant.
H-480.951	Fingerstick And Single-Use Point-of-Care Blood Testing Devices Should Not Be Used For More Than One Person	Our AMA encourages improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients. Citation: (Res. 515, A-11)	Retain; still relevant.
H-480.981	Cryotherapy, Therapeutic Ultrasound and Diathermy	Our AMA recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician. Citation: (BOT Rep. P, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-490.916	Health Insurance and Reimbursement for Tobacco Cessation and Counseling	Our AMA: (1) (a) continues to support development of an infrastructure for tobacco dependence treatment; (b) will work with the U.S. Public Health Service, particularly the Agency for Health Research and Quality, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction; (c) urges third party payers and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (d) supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts; (2) (a) requests Congress to provide matching	Retain, still relevant.

		funds for Medicaid coverage for evidence-based programs and Food and Drug Administration (FDA)-approved products that lead to smoking cessation; and (b) seeks the requirement that state Medicaid programs, prepaid health plans, and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages. Citation: (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Reaffirmation A-11)	
H-495.983	Tobacco Litigation Settlements	Our AMA: (1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)	Retain, still relevant.
H-50.995	Voluntary Donations of Blood and Blood Banking	Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply;	Retain; still relevant.

		(2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. Citation: (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11)	
H-525.985	Safety and Performance Standards for Mammography	Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks; (2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals; (3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and (4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography. Citation: (BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-525.986	Guidelines and Medicare Coverage for Screening Mammography	Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age.	Retain; still relevant.

		Citation: (BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-60.928	Body Image and Advertising to Youth	Our AMA encourages advertising associations to work with public and private sector organizations concerned with child and adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. Citation: (Res. 413, A-11)	Retain; still relevant.
H-60.929	National Child Traumatic Stress Network	Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative ~~at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network.~~ Citation: (Res. 419, A-11)	Retain in part, the FY 2011 level mentioned is outdated and should be deleted.
H-60.955	Screening Pediatric and Adolescent Injury Victims for Drugs and Alcohol	Our AMA: (1) supports drug and alcohol screening as an appropriate component of a comprehensive medical evaluation for pediatric and adolescent injury victims when clinically indicated; and (2) encourages physicians to actively pursue appropriate referral and treatment when clinically indicated for all pediatric and adolescent injury patients who test positive for the presence of drugs or alcohol. Citation: (Res. 408, I-94; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.971	Removal of High Alcohol Content from Medications Targeted for Use by Children and Youth	Our AMA encourages pharmaceutical companies to limit the alcohol content of their medications to the minimum amount necessary as determined solely by the physical and chemical characteristics of the medication. Citation: (Sub. Res. 507, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.974	Children and Youth With Disabilities	It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and	Retain; still relevant.

		youth with disabilities receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. Citation: (CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-60.976	Genetic and Medical History of the Adopted	It is the policy of the AMA (1) to assist the appropriate bodies to develop a medical and genetic history form which would become, and remain, protected information and part of an adopted individual's permanent record on their entry into the fostercare/adoption system; and (2) to draft model state legislation which clearly mandates all appropriate agencies to furnish to the adoptive parents, when possible, the appropriate medical and genetic family history furnished by birth parents, with a mechanism to protect the confidentiality of all parties. Citation: (Res. 512, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Medical and genetic history forms exist and are now readily available on many websites discussing adoption, including the CDC website. Additionally, the AMA developed model state legislation "To Require the Provision of the Genetic and Medical History of The Adopted to Adoptive Parents."
H-75.990	Development and Approval of New Contraceptives	Our AMA (1) supports ~~congressional~~ efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA. Citation: (BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part.
H-75.992	Family Planning Clinic Funds	Our AMA supports the concept of adequate funding for family planning programs. Citation: (Res. 102, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 227, A-11)	Retain; still relevant.

H-90.996	Education of <u>Children with Disabilities Handicapped Children</u>	Our AMA supports efforts to ensure an appropriate role for physicians in the development of special education programs for ~~handicapped~~ <u>children with disabilities</u> . Citation: (BOT Rep. I, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.963	Standardization of Collection and Custody Procedures of Body Fluid Specimens	~~It is the policy of the~~ Our AMA ~~to seek to have~~ supports the use of standardized procedures, containers and forms ~~developed that will to~~ satisfy the requirements of all requesting entities ~~which will reduce the hassle which currently exists in for~~ processing specimens <u>of body fluids</u> for drug <u>testing screens</u> and for insurance applications. Citation: (Res. 501, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended as standardized procedures have been outlined.
H-95.965	Residential Treatment for ~~Drug Addicted Women with Substance Use Disorder~~	Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. Citation: (Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.978	<u>Harmful Drug Abuse</u> Use in the United States - Strategies for Prevention	Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors. (2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of <u>harmful</u> drug and alcohol ~~abuse~~ prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills. (3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of <u>harmful</u> drug and alcohol ~~abuse~~ . (4) Supports the development of advanced educational programs to produce qualified	Retain in part to eliminate stigmatizing language. Remains relevant.

		prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations. (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities. (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of <u>harmful</u> alcohol and drug ~~ab~~use. Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021)
Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings
(Reference Committee E)

EXECUTIVE SUMMARY

Objective. The term “excited delirium” (ExD) is controversial and lacks a defined set of behavioral signs and symptoms used to identify a person in distress and in need of urgent medical or psychiatric help. Additionally, several media reports have recently highlighted the use of ketamine and other sedative/hypnotic agents by non-medical professionals to chemically incapacitate a person for a law enforcement purpose, and in many cases, ExD is listed as the reason for the use of a sedative/hypnotic agent. The Board of Trustees has requested that the Council on Science and Public Health study the use of ketamine and chemical restraints in the context of “excited delirium” and report back to the House of Delegates.

Methods. English-language reports were selected from a PubMed and Google Scholar search using the text terms “excited delirium,” “delirium,” “fatalities excited delirium,” “excited delirium restraint,” “excited delirium sedatives,” “excited delirium ketamine,” “police ketamine,” “EMS ketamine,” and “crisis response team.” Articles were filtered based on relevance. Additional articles were identified by manual review of the references cited in these publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. The assessment, diagnosis, and treatment of ExD remains controversial. Despite a lack of scientific evidence, a universally recognized definition, a clear understanding of pathophysiologic mechanisms, or a specific diagnostic test, law enforcement and EMS personnel are taught that ExD is a potentially deadly medical condition. Even deaths attributed to ExD have no consistent anatomical findings, resulting in ExD diagnosis being one of exclusion, defined by epidemiology and the subjective description of a clinical presentation. The individuals most likely to be disproportionately identified as experiencing ExD, and to die from resulting first responder actions, or as a consequence of administration of chemical sedation for a presumed case of ExD, are otherwise healthy Black males in their mid-30s who are viewed as aggressive, impervious to pain, displaying bizarre behavior, and using substances – characterizations that may be based less on evidence and more on generalizations, misconceptions, bias, and racism. Additionally, the identification of ExD has frequently been used in defense cases of law enforcement violence, despite reported autopsy results listing asphyxiation as the cause of death.

Conclusion. Reviews of law enforcement agencies and EMS have been called for to evaluate the prevalence of ketamine use in the field in unmonitored individuals and also to assess that training and guidelines for law enforcement and EMS have been established by supervising medical and behavioral health specialists. Such reviews are appropriate. It is important to assure that de-escalation training be widely implemented, and that personnel are conducting themselves according to guidelines and training to ensure patient safety. New crisis intervention team models in which medical and behavioral health specialists, not police, are those first deployed to respond to behavioral emergencies in the community should be encouraged. These models can help assure that decision makers in medical and mental health emergencies who are most appropriate to the circumstances are present with first responders, and that administration of any pharmacological treatments in a non-hospital setting is done equitably, in an evidence-based, anti-racist, and stigma-free way.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-JUN-21

Subject: Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee E

BACKGROUND

Recent media reports refer to “excited delirium” in discussions about police brutality and the use of conducted electrical devices (CED).¹⁻⁴ The term “excited delirium” is controversial and lacks a defined set of behavioral signs and symptoms used to identify a person perceived as in distress and in need of urgent medical or psychiatric help. Additionally, several media reports have recently highlighted the use of ketamine and other sedative/hypnotic agents by non-medical professionals to chemically incapacitate a person for a law enforcement purpose and not for a legitimate medical reason.⁴⁻⁶ In many cases, “excited delirium” is listed as the reason for the use of a sedative/hypnotic agent. The AMA Board of Trustees has requested that the AMA Council on Science and Public Health study the use of ketamine and chemical restraints in the context of “excited delirium” and report back to the AMA House of Delegates.

METHODS

English-language reports were selected from a PubMed and Google Scholar search using the text terms “excited delirium,” “delirium,” “fatalities excited delirium,” “excited delirium restraint,” “excited delirium sedatives,” “excited delirium ketamine,” “police ketamine,” “EMS ketamine,” and “crisis response team.” Articles were filtered based on relevance. Additional articles were identified by manual review of the references cited in these publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

AMA POLICY

No current AMA policy exists related specifically to excited delirium or the use of chemical restraints by law enforcement. AMA Policy H-515.968, “Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol,” emphasizes that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. Policy H-345.979, “Evaluation of Delirium,” supports efforts to educate physicians regarding the importance of evaluation of delirium for high-risk patients and patients who are symptomatic.

AMA has several policies related to law enforcement that are applicable to the topic of this report. Policy H-65.954, “Policing Reform,” recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA’s willingness to work with interested national, state, and local medical societies in a public

1 health effort to support the elimination of excessive use of force by law enforcement officers, states
2 that AMA will advocate against the utilization of racial and discriminatory profiling by law
3 enforcement through appropriate anti-bias training, individual monitoring, and other measures, and
4 will advocate for legislation and regulations which promote trauma-informed, community-based
5 safety practices. Policy H-345.972, "Mental Health Crisis Interventions," supports jail diversion
6 and community based treatment options for mental illness, implementation of law enforcement-
7 based crisis intervention training programs for assisting those individuals with a mental illness,
8 such as the Crisis Intervention Team model programs, federal funding to encourage increased
9 community and law enforcement participation in crisis intervention training programs, and
10 legislation and federal funding for evidence-based training programs by qualified mental health
11 professionals aimed at educating corrections officers in effectively interacting with people with
12 mental health and other behavioral issues in all detention and correction facilities. Policy
13 H-145.977, "Use of Conducted Electrical Devices by Law Enforcement Agencies," recommends
14 that law enforcement departments and agencies should have in place specific guidelines, rigorous
15 training, and an accountability system for the use of CEDs that is modeled after available national
16 guidelines, encourages additional independent research involving actual field deployment of CEDs
17 to better understand the risks and benefits under conditions of actual use, and urges law
18 enforcement departments and agencies have a standardized protocol developed with the input of
19 the medical community for the evaluation, management and post-exposure monitoring of subjects
20 exposed to CEDs.

21
22 AMA has policy related to Emergency Medical Services (EMS) and prehospital patient care.
23 Policy H-130.976, "On-Site Emergency Care" reaffirms endorsement of the concept of appropriate
24 medical direction of all prehospital emergency medical services and notes that trauma management
25 differs markedly between locales, settings, and types of patients receiving care and for these
26 reasons, physician supervision of prehospital services is essential to ensure that the critical decision
27 to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly. Policy
28 H-160.949, "Practicing Medicine by Non-Physicians" opposes allowing non-physician groups to
29 engage in the practice of medicine without physician (MD, DO) training or appropriate physician
30 (MD, DO) supervision and supports the requirement of appropriate physician supervision of non-
31 physician clinical staff in all areas of medicine. Policy H-130.937, "Delivery of Health Care by
32 Good Samaritans" notes that bystander physicians should recognize that prehospital EMS systems
33 operate under the authority and direction of a licensed EMS physician, who has both ultimate
34 medical and legal responsibility for the system.

35
36 Ethical Opinion 1.2.7, "Use of Restraints," states that all individuals have a fundamental right to be
37 free from unreasonable bodily restraint. At times, however, health conditions may result in
38 behavior that puts patients at risk of harming themselves. In such situations, it may be ethically
39 justifiable for physicians to order the use of chemical or physical restraint to protect the patient.
40 Except in emergencies, patients should be restrained only on a physician's explicit order. Patients
41 should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.
42 Physicians who order chemical or physical restraints should: (a) Use best professional judgment to
43 determine whether restraint is clinically indicated for the individual patient. (b) Obtain the patient's
44 informed consent to the use of restraint, or the consent of the patient's surrogate when the patient
45 lacks decision-making capacity. Physicians should explain to the patient or surrogate: (i) why
46 restraint is recommended; (ii) what type of restraint will be used; (iii) length of time for which
47 restraint is intended to be used. (c) Regularly review the need for restraint and document the review
48 and resulting decision in the patient's medical record. In certain limited situations, when a patient
49 poses a significant danger to self or others, it may be appropriate to restrain the patient
50 involuntarily. In such situations, the least restrictive restraint reasonable should be implemented
51 and the restraint should be removed promptly when no longer needed.

EXCITED DELIRIUM

Delirium is a well-defined clinical entity with both hypoactive and hyperactive manifestations, commonly caused by an underlying medical condition and not associated with sudden death. The term “excited delirium” (ExD) has been used since the 1980s to refer to a subcategory of delirium that has primarily been described in forensic literature and the term “excited delirium syndrome” (ExDS) was originally used in the forensic literature to describe findings in a subgroup of patients with ExD who suffered lethal consequences from untreated severe agitation. Currently, ExD and ExDS are used interchangeably in literature and media.

History

In 1849, the lead psychiatrist at McLane Asylum for the Insane introduced a condition synonymous to ExD into medical literature as “Bell Mania.”⁷ The term “excited delirium” first emerged in 1985 from two University of Miami professors who set out to explain a new phenomenon of sudden deaths, mostly in police custody, of otherwise healthy men under the influence of a non-lethal amount of cocaine.^{8,9} Soon after, the term gained academic traction, as the United States saw a dramatic rise in use of cocaine and other sympathomimetic substances along with increased efforts to deinstitutionalize patients with chronic mental illness.¹⁰ Currently, ExD and ExDS are referred to as conditions of illness marked by a combination of autonomic hyperadrenergic dysfunction, agitation, and delirium. The purported root of ExD, involving psychiatric, neurologic, and metabolic imbalance, is highly variable and linked to a complicated array of co-morbid and severe health issues.¹¹

Historically, the concept of ExD was synonymous with death, but over time the term has made its way into the emergency medicine, psychiatric, law enforcement, prehospital, and medicolegal literature to generally describe patients displaying altered mental status with severe agitation and perceived combative or assaultive behavior that has eluded a unifying, prospective clinical definition. Studies have failed to define ExD as one specific clinical entity, and it remains without a plausible biological pathway to sudden death. Multiple published series highlight that when CEDs and/or police restraints are used, ExD most often becomes fatal.¹²⁻¹⁷ CSAPH Report 6-A-09, *Use of Tasers® by Law Enforcement Agencies*, included a very brief paragraph on ExD and notes that ExD is not a validated diagnostic entity in either the World Health Organization’s International Classification of Diseases or the *Diagnostic and Statistical Manual of Mental Disorders*, but is widely accepted in forensic pathology and is cited by medical examiners to explain the sudden in-custody deaths of individuals who are combative and highly agitated.¹⁸

Pathophysiology

Although it is extensively used in academic and medical literature, considerable debate exists in medicine about how to characterize ExD and ExDS, if they even exist, and how ExD contributes to sudden death. The pathophysiologic mechanisms of ExD have not been elucidated and ExD does not currently have a known etiology.^{10,19-21} However, ExD has been characterized in the literature by delirium, agitation, acidosis, and hyperadrenergic autonomic dysfunction, typically in the setting of drug use or serious mental illness or a combination of both.¹¹ Currently, a general function of the sympathetic nervous system is associated with the listed clinical manifestations of ExD, with possible nervous system dysfunction in some way inciting symptoms. While some authors correlate elevated synaptic dopamine levels to ExD, its causes are yet to be discovered and the absence of a unique pathophysiologic cause or specific diagnostic test remains.²²⁻²⁴

No consistent anatomical features define ExD. Due to the biological ambiguity in diagnosing ExD, postmortem findings from autopsy and forensic evidence collection to identify or support ExD are unlikely, and a postmortem diagnosis of ExD is one of exclusion.^{8,17,25,26} Because ExD does not currently have a known specific etiology or a consistent anatomic feature, it can only be explained by its epidemiology and described clinical presentation.²⁰

Epidemiology

Studies have shown that delirium occurs in between 11 and 42 percent of general medical inpatients and 50 percent of elderly hospitalized patients. This figure is even greater for those with pre-existing cognitive impairments, terminal illness, or in need of intensive care.²⁷ Patients diagnosed with delirium are found to have extended stays in the hospital by five to ten additional days, and are more likely to be transferred to a long-term care facility post-release.²⁸

Those who are most likely to be identified as having ExD are men, with 83 to 95 percent of ExD cases occurring in this population.²⁴ Otherwise healthy males in their mid-30s who are seen as “aggressive, impervious to pain, and display bizarre behavior” have the highest rate of mortality from ExD/ExDS.¹⁰ Despite similar rates of drug use across race and ethnicity in the United States,²⁹ epidemiological studies show that it is specifically and disproportionately younger Black men who use cocaine and other psychostimulants and are in police custody that are at highest risk for death from ExD/ExDS.^{24,30,31} Mortality rates associated with ExD/ExDS have been reported to be between 8 to 16.5 percent.^{11,24,32}

LAW ENFORCEMENT, EMS, AND EXCITED DELIRIUM

Because of its reference in forensic literature, law enforcement groups and EMS have started training staff to identify ExD as a potentially deadly medical condition, despite the absence of a unique pathophysiologic cause or specific diagnostic test.^{33,34} ExD often presents itself as a behavioral issue initially evaluated by law enforcement with subsequent EMS involvement.^{11,35} Additionally, the identification of ExD/ExDS has been frequently used in defense cases of police violence.^{9,36} Some of the cases in which ExD has been invoked in defending the deaths of people, all Black, in police custody include Natasha McKenna,¹⁴ Manuel Ellis,² Elijah McCain,⁵ George Floyd,³ and Daniel Prude.¹

The prevalence of ExD appears to vary widely, both because of varying definitions and context. Reports estimate that ExD is in question in more than 3 percent of police interventions that use force and more than 10 percent of the deaths that occur within law enforcement custody are associated with ExD.²⁴ Reports also note that between 38 and 86 percent of all fatal ExD cases occur in police custody²⁴ and that law enforcement officers encounter one person with ExD in every 58 use of force incidents.²⁵ In cases of suspected ExD, law enforcement officers are encouraged to contact EMS personnel; the combined effort of EMS and law enforcement to provide effective care to those with ExDS has been termed the “dual response.”^{33,34} Training for EMS personnel states that treatment of ExDS must be focused on rapidly, safely, and effectively sedating the patient and providing intensive, supportive care.³⁷

Since ExD lacks a consensus clinical definition and few pathophysiological findings exist about the condition, wrongly characterizing symptoms as ExD, especially by law enforcement with little medical knowledge, frequently leads to additional and potentially fatal medical complications including hypoxia.^{17,38-40} The profile of a death attributed to ExD is usually a sudden, unexpected one that occurs most frequently in the summer.⁴¹ It usually occurs immediately following chemical or physical restraint to control ExD and occurs most frequently when the patient is in the prone

position; both chemical restraints and CEDs have been cited to result in sudden death due to ExD.^{15,17,42} An *FBI Law Enforcement Bulletin* article discussing ExD describes it as “a serious and potentially deadly medical condition involving psychotic behavior, elevated temperature and an extreme flight-or fight response,” and notes that “these patients often die within 1 hour of police involvement.”³³

Studies have evaluated the factors associated with death attributed to ExD in police custody and the confounding effect that restraint has on the risk of death. Results have indicated that a diagnosis of ExD and potentially fatal restraint are “inextricably interwoven.”^{43,44} Some form of restraint was described in 90 percent of all ExD deaths, making it the most common factor that is a plausible cause or contributing cause of the death. Authors note that there is no evidence to support ExD as a cause of death in the absence of restraint.⁴⁴ The reported autopsy results for the individuals referenced above, in which law enforcement officers cited ExD as the cause of death provide examples of this: in the death of Natasha McKenna, “excited delirium,” was noted although a stun gun was utilized 4 times resulting in loss of consciousness;¹⁴ the death of Elijah McClain was “undetermined,” although carotid hold and excessive restraint were utilized;⁵ the death of Manuel Ellis was reported as “hypoxia due to physical restraint;”² George Floyd died from “asphyxia due to neck and back compression;”³ and Daniel Prude’s death was due to “complications of asphyxia in the setting of physical restraint.”¹

While the mortality rate associated with ExD is estimated to be between 8 and 16.5 percent,^{11,24,32} in the past three decades, a significant decrease in restraint-related deaths of those with ExD has been noted. The period from 2004 to 2011 shows a 33 percent reduction in fatalities from ExD compared to the period 1988 to 1995; authors comment that the decrease is likely due to an increase in warnings and repeated recommendations concerning the association between restraint, especially in a prone position and fatal ExD.²⁴ However, little information related to the specific details of law enforcement or EMS training related to ExD could be located.

CHEMICAL RESTRAINT

A chemical restraint is when a drug is used to restrict the movement of a patient or in some cases to sedate a patient. Chemical restraint is used in emergency, acute, and psychiatric medical settings to reduce agitation, aggression, or violent behaviors. Drugs that are often used as chemical restraints include benzodiazepines, antipsychotics, and dissociative anesthetics. However, no drugs are U.S. Food and Drug Administration (FDA) approved for use as chemical restraints. The long history of restraint and associated controversies of the use of restraints (physical, mechanical, and chemical) in patients is outside of the scope of this report.

Drugs Used as Chemical Restraints

Medications that are typically used for chemical restraint include the dissociative ketamine, benzodiazepine sedatives such as midazolam, and antipsychotic medications including olanzapine or haloperidol, both alone or in combination.

Studies over the last several years have evaluated and compared the efficacy of sedation for several medications used for chemical restraint, as well as adverse effects associated with them.⁴⁵⁻⁴⁹ A recent systematic review summarizes available evidence on the effectiveness and safety of chemical restraint from 21 randomized controlled trials conducted in pre-hospital, hospital emergency department, or ward settings and notes limited comparability between studies in drug choice, combination, dose, method of, or timing of repeat administrations. Drugs used in chemical restraint and included in the review include olanzapine, haloperidol, droperidol, risperidol,

flunitrazepam, midazolam, promethazine, ziprasidone, sodium valproate, or lorazepam. The review notes little clarity about the superiority of any of the drugs and recommends additional research on the topic.⁵⁰

Because sedation with slower-onset chemical restraints, such as haloperidol and some benzodiazepines present a risk of delay to adequate sedation, ketamine has emerged as a potentially preferred drug for the control of patient agitation in a pre-hospital context and for a law enforcement purpose.^{35,37,39,40,51-54} Although little literature exists directly reporting the frequency of EMS use, authors note that this medication could easily be implemented into out-of-hospital protocols and that ketamine offers a “safe and effective method of controlling the severely agitated patient.”^{35,37}

Ketamine

Ketamine is FDA approved for use as an anesthetic agent for diagnostic and surgical procedures and esketamine (a pure ketamine stereoisomer) is FDA approved for treatment-resistant depression. Ketamine and esketamine are classified as Schedule III controlled substances.

Ketamine is commonly used off-label in medical settings as an analgesic, antidepressant, and anti-inflammatory medication. No FDA-approved indication for use to treat ExD exists, which is understandable given that there is no medical consensus on definitions of or diagnostic criteria for ExD. Therefore, no standard dosing regimen has been established and there has been no consideration of co-morbid medical conditions for ketamine use for ExD. A rapidly growing movement calls for expanded use of ketamine for several applications, both in and out of the hospital, including for sedation of agitated patients in non-clinical situations and for restraint in custody.^{35,55}

Ketamine Use as a Chemical Restraint by Law Enforcement and EMS

Police officers and EMS professionals are the most likely first responders to encounter agitated patients exhibiting what they might consider to be symptoms of ExD. While law enforcement usually evaluates this syndrome, it is usually EMS personnel who provide the sedation, in the “dual response” model. While several chemical restraints are used to sedate those purportedly experiencing ExD within law enforcement custody and in EMS contexts, most commonly the sedative is ketamine. Authors report that the use of ketamine for restraint of an agitated patient induces rapid, predictable sedation within three to four minutes when given by intramuscular injection.^{37,54,56}

A recent national survey assessed ketamine training, use, and perceptions among paramedics in civilian prehospital settings. The survey noted that training related to ketamine use was commonly reported among paramedics, however, few are authorized to administer the drug according to their agency protocol. Of those paramedics authorized to use ketamine, most had limited experience administering the drug, but have the perception that the use of ketamine for sedation is safe and effective.⁵² Dosing guidelines, safety profile, and efficacy have been described in only a limited fashion for the use of ketamine to chemically restrain a patient in a pre-hospital scenario.⁵¹

Many police departments have seen a dramatic rise in ketamine administration over the past several years. As an example, a 2018 City of Minneapolis report “MPD Involvement in Pre-Hospital Sedation” documented an average of 4 cases of ketamine use per year prior to 2015, 14 uses in 2015, and 62 instances in 2017.⁵⁷ From January 2018 through April 2018, 11 instances of ketamine use were documented in police reports, exceeding the annual use in each year from 2010-2014.⁵⁷

1 Additionally, the report from Minneapolis presented 8 cases that occurred between 2016 and 2018
 2 in which EMS professionals and Minneapolis Police Department (MPD) officers cooperated in
 3 order to administer ketamine. These cases involved instances in which the police officers, with
 4 limited medical training, directed EMS professionals to use ketamine.⁵⁷ A recent investigation of
 5 the death of Elijah McCain in Colorado determined that the use of ketamine contributed to his
 6 death.⁵⁸

7
 8 Little information related to the specific details of law enforcement or EMS training related to the
 9 use of ketamine or other chemical restraints could be located. Reviews of law enforcement
 10 agencies and EMS have been called for to evaluate the prevalence of ketamine use in the field in
 11 unmonitored individuals and to assess that training and guidelines have been established by
 12 supervising medical and behavioral health specialists, are appropriate, include de-escalation
 13 training, and personnel are conducting themselves according to guidelines and training to ensure
 14 patient safety.^{35,57,58} Additionally, agencies currently using ketamine for sedation of agitation are
 15 encouraged to report their outcomes and protocols to increase the body of evidence and determine
 16 best safe practices for this indication.³⁵

17 18 *Ketamine Pharmacology in Pre-hospital Contexts*

19
 20 Ketamine dose dependently exerts broad influences on consciousness and perception, with some
 21 patients reporting dissociative and extracorporeal sensations. The most common psychoactive
 22 effects reported after a single subanesthetic intravenous administration of ketamine include
 23 dissociation, positive psychotomimetic effects (conceptual disorganization, hallucinations,
 24 suspiciousness, unusual thought content, and frank paranoia), and negative psychotomimetic
 25 effects (blunted affect, emotional withdrawal, and psychomotor retardation). In addition, studies
 26 have identified unfavorable effects of administration of ketamine on cognition (including amnesia),
 27 vestibular perturbations, nausea/vomiting, tachycardia, hypertension, palpitations, hypersalivation,
 28 and respiratory depression. Ketamine has also been found to have negative interactions with
 29 alcohol in intoxicated individuals and those taking MAO inhibitors, which is of concern because
 30 when ketamine is used by EMS in out-of-hospital settings, individuals may be under the influence
 31 of alcohol, cannabis, sedative-hypnotics, or other psychoactive drugs or under medical treatment
 32 with a pharmaceutical with potential adverse drug-drug interactions with ketamine.^{48,59-62}

33
 34 Because of the ketamine dose-response and side effects, careful administration and medical
 35 expertise is necessary, especially in non-medical and non-hospital contexts.^{17,38-40} In general, the
 36 duration of sedation should only be long enough to allow for patient assessment, initial treatment,
 37 and transfer to a medical facility; restraint beyond this timeframe may induce additional medical
 38 complications. Ketamine dosing is dependent on a person's body weight, with a reported standard
 39 dosing of 5mg per kilogram of bodyweight starting at 250 mg for pre-hospital treatment.^{44,51,63,64}
 40 Because of this weight dosing requirement, incorrect dosing of ketamine by law enforcement or
 41 EMS can and has led to serious adverse events or death.⁵⁸ A recent investigation of the death of
 42 Elijah McClain in Aurora, Colorado found that an incorrect estimation of weight for a weight-
 43 based dose calculation contributed to his death.⁵⁸ Additionally, several studies have reported that
 44 while ketamine provides rapid sedation for agitated patients, its use in a pre-hospital setting is
 45 associated with higher intubation and hospital admission rates when used by
 46 EMS.^{35,38,48,51,54,60,62,65,66} Studies have also linked the use of ketamine to death from metabolic
 47 acidosis.⁶⁷⁻⁶⁹

CRISIS INTERVENTION TEAM PROGRAMS

Crisis Intervention Team programs (CITs) are community partnerships of law enforcement, behavioral health providers, people with mental and substance use disorders, along with their families and others. CITs have become a globally recognized model for safely and effectively assisting people who experience crises in the community. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that the need for CIT programs is urgent, as communities are challenged with insufficient mental health funding and services.⁷⁰ Advocates of CITs, including the National Alliance on Mental Illness (NAMI), note that the programs can reduce police encounters and arrests of people with mental illness while simultaneously increasing the likelihood that individuals will receive mental health services.⁷¹⁻⁷³ Additional goals of CITs include improving police responses to people in crisis; diverting individuals from the criminal justice system when appropriate; and developing more robust community-based crisis-response systems that minimize both the role of law enforcement and the need to utilize emergency departments.⁷⁴ A foundational aspect of successful CITs is a strong and ongoing community partnership.⁷⁴

CITs promote both law enforcement officer safety and the safety of the individual in crisis. NAMI notes that CITs give law enforcement officers more tools to do their job safely and effectively and promotes the expansion of CITs nationwide, providing resources and working with stakeholders to establish standards and promote innovation for CITs.⁷³ While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is core to the model. SAMHSA notes that for safety and optimal engagement, two person CIT teams should be put in place to support communities and EMS should be aware of the teams and partner as warranted. SAMHSA guides also note minimum expectations for CITs, including the involvement of a licensed and/or credentialed behavioral health clinician, response to where the person in need is located, and connecting the individual to appropriate care, with a warm hand-off and coordinated transportation. SAMHSA guides and CIT International, the leading national organization promoting successful CIT models, detail best practices for CIT services^{75,76} and experts have documented and noted challenges for rural communities.⁷⁷

The Denver Support Team Assisted Response program (STAR), which has been operational for six months, is an example of a CIT. STAR pairs a mental health clinician and a paramedic to address low-level incidents, such as trespassing and mental health episodes, that would have otherwise fallen to uniformed law enforcement officers carrying firearms. In its first six months, STAR has responded to 748 incidents, none of which required police or led to arrests or jail time.^{78,79}

Officials note that “STAR represents a more empathetic approach to policing that keeps people out of an often-cyclical criminal justice system by connecting people with services like shelter, food aid, counseling, and medication. The program also deliberately cuts down on encounters between uniformed officers and civilians.” The STAR policing alternative empowers behavioral health experts to dictate patient interactions, even when police officers are around, and has been hailed as a success in local Denver communities.^{78,79} Many communities around the United States are exploring alternatives to incarceration and law enforcement response to minor incidents.

NATIONAL ASSOCIATION POSITIONS

The American Psychiatric Association (APA) released a position statement in 2020 related to ExD and the use of ketamine. APA does not recognize ExD as a mental disorder and states that the term should not be used until a clear set of diagnostic criteria are validated. APA notes that persons being detained by the police and described as having ExD have frequently received medication

from EMS personnel intended to chemically sedate them, without a medical condition warranting the use of the drug. The APA statement further cautions that chemical sedation medications, including ketamine, used outside of hospital contexts have significant risks, including respiratory suppression. APA also states that an investigation should be undertaken of cases labeled as ExD, that all relevant data be analyzed for disproportionate application of the term, and that all jurisdictions should develop, implement, and routinely update evidence-based protocols for the administration of chemical restraint medications.⁸⁰

The American College of Emergency Physicians (ACEP) recognizes ExD as a medical condition and notes that the exact pathophysiology of ExD remains unidentified.^{11,32,81} In articles on the topic, ACEP representatives note that a large component of treating patients is helping law enforcement and EMS recognize possible ExDS patients, and that prehospital ExDS should be presumed if a patient is disoriented or not making sense, constantly physically active, impervious to pain, has superhuman strength, is sweating and breathing rapidly, has tactile hyperthermia, and fails to respond to a police presence. ACEP experts have also advocated that chemical sedation, with ketamine or benzodiazepines, is a first-line treatment.^{32,81}

In a 2020 statement, ACEP and the American Society of Anesthesiologists (ASA) discussed the safe use of ketamine in the emergency department and in prehospital care for effective pain management, sedation, the control of delirium in acute psychotic emergencies and drug intoxications. ACEP and ASA noted the dependence on an appropriate medical assessment by a paramedic with medical direction. The statement notes firm opposition to the use of ketamine or any other sedative/hypnotic agent to chemically incapacitate someone solely for a law enforcement purpose and not for a legitimate medical reason.⁸²

The American College of Medical Toxicologists (ACMT) hosts educational information related to ExD and ExDS, including definitions, signs and symptoms, and treatment with chemical support/sedation.⁸³ In a statement released in 2020, ACMT recognized ExD as a condition that warrants consideration of the decision to administer sedating medications. Based on current evidence, ACMT supports the use of sedative and dissociative medications by appropriately trained prehospital paramedical professionals for treatment of severe agitation when other measures have failed, but ACMT does not support the use of these medications solely for the purpose of behavior control on behalf of law enforcement.⁸⁴

In 2020, ACMT, the American Society of Addiction Medicine (ASAM), and the Opioid Response Network (ORN) co-hosted an Addiction Toxicology Case Conference on the topic of intoxication and ExD.⁸⁵ The webinar, for continuing medical education credit, featured “discussion of drug-induced agitated delirium with experts dissecting the mechanism and common course of events that occur in the most severe type of agitated delirium, often referred to as Excited Delirium Syndrome. Myths and misperceptions in care of patients with agitation and delirium [were] addressed, as [was] discussion of the appropriate use of sedation...”⁸³

The National Association of EMS Physicians (NAEMSP) recognizes that EMS personnel often encounter agitated and combative patients, and these patients frequently require clinical treatment and transportation. A 2016 statement details the NAEMSP position on a several issues related to patient restraint. Notably, NAEMSP believes that EMS agencies should develop scientific protocols for dealing with violent or combative patients, that EMS agencies must assure that all personnel are knowledgeable about the clinical conditions that are associated with agitated or combative behavior and are trained to apply the principles of the system’s restraint protocol during patient care. The NAEMSP position statement provides significant details about restraint protocols, notes the use of chemical restraint for ExD, and that chemical restraint, usually with a

1 butyrophenone, a benzodiazepine, ketamine or other dissociative agents, or a combination of these
2 agents, is an effective and safe method of protecting the violent or combative patient from self-
3 injury. Importantly, the NAEMSP notes that local law enforcement restraint policies/practices may
4 differ from EMS-based restraint protocols, but both agencies should recognize their roles and work
5 cooperatively and proactively to ensure the safe care of patients when application of restraint(s) is
6 necessary.⁸⁶

7 8 CONCLUSION

9
10 The assessment, diagnosis, and treatment of ExD remains controversial. Despite a lack of scientific
11 evidence, a universally recognized definition, a clear understanding of pathophysiologic
12 mechanisms, or a specific diagnostic test, law enforcement and EMS personnel are taught that ExD
13 is a potentially deadly medical condition – including at time, by physicians. Even deaths attributed
14 to ExD have no consistent anatomical findings, resulting in ExD diagnosis being one of exclusion,
15 defined by epidemiology and the subjective description of a clinical presentation. The individuals
16 most likely to be disproportionately identified as experiencing ExD, and to die from resulting first
17 responder actions, or as a consequence of administration of chemical sedation for a presumed case
18 of ExD, are otherwise healthy Black males in their mid-30s who are viewed as aggressive,
19 impervious to pain, displaying bizarre behavior, and using substances – characterizations that may
20 be based less on evidence and more on generalizations, misconceptions, bias, and racism.
21 Additionally, the identification of ExD has frequently been used in defense cases of law
22 enforcement violence, despite reported autopsy results listing asphyxiation as the cause of death.

23
24 While chemical restraint is used in emergency, acute, and psychiatric medical settings to reduce
25 agitation, aggression, or violent behaviors, a rapidly growing movement calls for expanded use of
26 chemical restraint, specifically using ketamine, for several applications, both in and out of the
27 hospital, including for sedation of agitated patients in non-clinical situations and for chemical
28 restraint of persons in law enforcement custody. Police officers and EMS professionals are the
29 most likely first responders to encounter patients perceived to be exhibiting purported ExD. While
30 law enforcement usually evaluates this syndrome, it is usually EMS personnel who provide the
31 sedation, in the “dual response” model.

32
33 Reviews of law enforcement agencies and EMS have been called for to evaluate the prevalence of
34 ketamine use in the field in unmonitored individuals and to assess that training and guidelines have
35 been established by supervising medical and behavioral health specialists. Such reviews are
36 appropriate. It is important to assure that de-escalation training be widely implemented, and that
37 personnel are conducting themselves according to guidelines and training to ensure patient safety.
38 New CIT models in which medical and behavioral health specialists, not police, are those first
39 deployed to respond to behavioral emergencies in the community should be encouraged. These
40 models can help assure that decision makers in medical and mental health emergencies who are
41 most appropriate to the circumstances are present with first responders, and that administration of
42 any pharmacological treatments in a non-hospital setting is done equitably, in an evidence-based,
43 stigma-free way.

RECOMMENDATION

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. That the following new AMA policy be adopted:

Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings
Our American Medical Association:

1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;
2. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.
3. Opposes the use of sedative/hypnotic agents, including ketamine, to chemically restrain an individual solely for a law enforcement purpose;
4. Recognizes that drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;
5. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
 - a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
 - b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
 - c. Assess that training and guidelines have been properly established by supervising medical and behavioral health specialists, are appropriate, and include de-escalation training; and
 - d. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training to ensure patient safety; and
6. Urges law enforcement and emergency medical service personnel to participate in appropriate training that minimally includes de-escalation techniques and the appropriate use of drugs used to restrain individuals; and
7. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.

(New HOD Policy)

- 1 2. That Policy H-65.954, "Policing Reform," which recognizes police brutality as a
2 manifestation of structural racism which disproportionately impacts Black, Indigenous, and
3 other people of color, notes AMA's willingness to work with interested national, state, and
4 local medical societies in a public health effort to support the elimination of excessive use
5 of force by law enforcement officers, states that AMA will advocate against the utilization
6 of racial and discriminatory profiling by law enforcement through appropriate anti-bias
7 training, individual monitoring, and other measures, and will advocate for legislation and
8 regulations which promote trauma-informed, community-based safety practices, be
9 reaffirmed. (Reaffirm Current AMA Policy)
10
- 11 3. That Policy H-345.972, "Mental Health Crisis Interventions," which supports jail diversion
12 and community based treatment options for mental illness, implementation of law
13 enforcement-based crisis intervention training programs for assisting those individuals with
14 a mental illness, such as the Crisis Intervention Team model programs, federal funding to
15 encourage increased community and law enforcement participation in crisis intervention
16 training programs, and legislation and federal funding for evidence-based training
17 programs by qualified mental health professionals aimed at educating corrections officers
18 in effectively interacting with people with mental health and other behavioral issues in all
19 detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy)

Fiscal Note: Less than \$1000

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REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021)
Addressing Increases in Youth Suicide
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families, peers, and communities. Youth and young adult suicide rates rose 54.7 percent from 2007 to 2018 even before the major behavioral and psychological disruptions caused by the COVID-19 pandemic.¹ Despite a small decrease in suicide mortality in 2018 and 2019 data, suicide deaths in youth and young adults overall have been steadily increasing since 2007 and in 2019 suicide was the second leading cause of deaths among those 10-24 years of age.² Due to the alarming increase in suicide and suicide risk in youth and young adults, the Council on Science and Public Health initiated this report to further examine this issue and to provide relevant updates to American Medical Association (AMA) policy.

Methods. English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide contagion,” “suicidal ideation,” and “suicidal thoughts and behavior.” Related search terms linked with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and “bullying.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. Increases in suicides and suicide attempts have occurred among both male and female youth, with males using more lethal means such as firearms in completed suicides. Youth and young adults in the Native American/Alaska Native demographic groups show the highest number of completed suicides and attempts. Increases in instances of cyberbullying are an important factor associated with youth suicide and requires additional attention. Increases in screen time and in the use of digital devices, the internet, and social networking sites are associated with decreases in time sleeping and increases in depression. Additionally, stresses and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for some youth and possibly increased suicidal ideation. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), substance use disorder, adverse childhood experiences, or other stressors are present, the risk for suicidal thoughts or behavior increases.

Conclusions. Enhancing physician capability and capacity to screen for, identify, and respond to risk factors for youth suicide are essential to effective suicide prevention efforts. Physicians who see patients in these age groups, and not solely pediatric psychiatrists and addiction medicine physicians, should have access to the tools to identify acute risk and respond with appropriate clinical interventions, linkages to appropriate counseling services, and safety planning. They should also be able to identify and promote relevant protective factors to mitigate the impact of underlying risk factors. Collectively, physicians, parents, teachers, peers, clergy, youth ministers, social workers, counselors, and others, are critical in identifying when a young person is experiencing a period of imminent risk and assisting in preventing suicide attempts.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-JUN-21

Subject: Addressing Increases in Youth Suicide

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

INTRODUCTION

In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families and communities. Suicides and suicide attempts among youth, ages 10-24 have increased steadily since 2007. Data shows that although suicides remained relatively stable in this age group from 2000 to 2007, rates started to rise in 2007 and increased 54.7 percent through 2018.¹ While we do not yet know the full impact of the COVID-19 pandemic on youth suicide, the potential mental health consequences of COVID-related stressors are of concern. As a result of the steady increase in youth suicides, the Council on Science and Public Health initiated this report to understand current risk and protective factors, examine evidence-based interventions for youth and young adult suicide, and to update American Medical Association (AMA) policy accordingly.

The focus of this report will be on children, adolescents, and young adults age 10-24, hereinafter referred to in this report as youth. Data and trends in suicide in populations beyond this age group, while important, are outside the scope of this report.

METHODS

English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide contagion,” “suicidal ideation,” “and “suicidal thoughts and behavior.” Related search terms linked with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and “bullying.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Much of the literature reviewed for this report uses the term “suicidal thoughts and behavior” or “STB” as shorthand to describe suicidal thoughts, ideation, planning, and suicide attempts. Non-suicidal self-injury (NSSI) is differentiated in the literature in the United States whereas in Europe it might be included as an STB. For the purposes of this report, the abbreviation STB will be used to mean suicidal thoughts, suicidal ideation and planning, and suicide attempts.

BACKGROUND

Addressing youth suicide is a critical and growing public health issue. Suicides in the United States rose since 2000, increasing 30 percent from 2000 to 2016, with rates increasing among all age groups in the 10-24 range and across 42 states. Rates of suicide in the 10-24 age group have risen 57.4 percent from 6.8 per 100,000 in 2007 to 10.7 per 100,000 in 2018. In 2017 approximately 2.4 percent of all students in grades 9-12 reported making a suicide attempt that required treatment by a physician or nurse.³ Suicide was the second-leading cause of death for young people ages 15 to 24, second only to accidents in 2019.² While more recent data suggest there was a modest decrease in youth suicide in 2018 and 2019, overall levels of suicide among youth are still significantly higher than they were ten years before. And since 2019 stress on youth as well as adults has increased in the wake of the disruption associated with the COVID-19 pandemic, such as physical distancing and social isolation^{1,2,4,5}

Total mortality of youth from suicide in 2017 was 6,200 deaths in those age 10-24, with that number rising to 6,807 in 2018.⁶ Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance Survey (YRBSS) data from 2019 show that more high school students were contemplating suicide, rising from 13.8 percent in 2009 to 18.8 percent in 2019.⁷ Of all high school students in 2019, 8.9 percent reported having attempted suicide, with prevalence estimates highest among females (11.0 percent) and black non-Hispanic students (11.8 percent).³ Completed suicides are more common in males at rates two to four times higher than females, but suicide attempts are 3-9 times more common in females overall.^{8,9} From 2009 through 2019, prevalence of suicide attempts increased overall and particularly increased among female, non-Hispanic white, non-Hispanic black, and 12th-grade students.^{7,10}

STB varies by race and ethnicity among youth. Native American Indian/Alaska Natives have had the highest suicide rate over the last 20 years. While suicide rates have historically been higher among White individuals than Black individuals, data suggests that suicide risk is increasing among Black youth. One study showed higher incidence of STB for Black youth in the 5-12 age group than White counterparts.¹¹ There is data showing overall increase in the rate of STB among Black youth age 12-17 through the period of 1991-2017, while rates for STB among White youth in that age group have decreased.¹⁰ Rates of STB in Hispanic/Latinx female young adults also increased between 2000 and 2015.^{12,13} In addition, sexual and gender minority youth are more likely to engage in suicidal behavior than their non-LGBTQ peers. It is important to understand the impact of structural racism, historical trauma, and accumulative stress on mental health in minority and historically marginalized communities, may contribute to depression and other risk factors for STB.¹⁴⁻¹⁶

In 2019 firearms were the leading cause of suicide death in those age 15-24 and the second leading cause of suicide death for those in the 10-14 age group. Suffocation is the other leading cause of suicide death among those 10-24. Firearms as a means of suicide have trended upward for young females and deaths from poisonings have decreased.^{2,5} In 2018, the Council on Science and Public Health released a report adopted by the House of Delegates on "The Physician's Role in Firearm Safety and recognized the role of firearms in suicides and encouraged physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.¹⁷

CURRENT AMA POLICY

Highlights of AMA policy related to youth suicide include recognizing teen and young adult suicide as a serious health concern Policy H-60.937, "Teen and Young Adult Suicide in the United

States.” Policy D-350.988, “American Indian / Alaska Native Teen Suicide” encourages significant funding for suicide prevention and intervention directed toward American Indian/Alaska Native communities. Policy H-60.927, “Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations,” also recognizes the special risk for LGBTQ+ teens and calls for partnering with public and private organizations to help reduce suicide among these teens. Policy H-515.952, “Adverse Childhood Experiences and Trauma-Informed Care,” recognizes the importance of trauma-informed care and the impact of adverse childhood experiences (ACEs) and trauma on patient health.

Policy H-60.911 “Harmful Effects of Screen Time in Children” encourages physicians to “assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits” and to advocate for education in schools about balancing screen time, physical activity, and sleep. Policy H-515.959 “Reduction of Online Bullying” addresses this urging social networking platforms to “define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging” as part of their Terms of Service agreements. In addition, Policy H-60.943 “Bullying Behaviors Among Children and Adolescents” addresses bullying in several ways, including urging physicians to be aware of the signs and symptoms of bullying in children and teens, to recognize the mental, emotional and physician effects of bullying and to counsel patients and parents on effective interventions and coping strategies.

RISK FACTORS FOR YOUTH SUICIDE

Various behavioral, emotional, psychological, and social risk factors for youth suicide have been well established, and include depression, anxiety, bullying, substance use disorder (SUD), trauma, family history of suicide, sexual orientation or sexual and gender minority status and other stressors.^{18,19} Prior suicide attempts are one of the most serious indicators of risk for subsequent self-harm and suicidal behavior.²⁰ Over 30 percent of youth suicides are preceded by a prior attempt, with boys with previous suicide attempts having a 30-fold increase for risk of a subsequent attempt in comparison with boys with no prior attempts. Girls with previous suicide attempts show a 3-fold increase in risk for subsequent attempts in comparison to girls with no prior attempts.⁸ The presence of multiple factors increases underlying risk. Prevention starts with a thorough understanding of risk factors. Identifying risk factors is essential but does not provide the ability to predict acute suicidality effectively and accurately. Underlying risk factors can exist for years without producing active suicidality and imminent risk of suicide, and no one risk factor alone can be an absolute predictor.^{18,19,21}

Role of Mental Health Disorders

Suicide is closely linked to mental health disorders, mainly depression and other mood disorders.^{22,23} Among all age groups, approximately 90 percent of people who complete a suicide have had at least one mental health disorder.²⁴ Risk is significantly increased for acute suicidality when there are psychotic symptoms and when there are family members who have mental health or SUD issues.^{25,26}

Data shows that depression in youth has been on the rise from 2005 to 2019. The 2019 National Survey on Drug Use and Health (NSDUH) indicates that among teens aged 12-17, rates of major depressive disorder increased 52 percent during the period between 2005 and 2017, and an increase of 63 percent was seen in young adults aged 18-25. Those trends were also accompanied by increases in reports of serious psychological distress and suicide related outcomes (STB and

suicide mortality) with a dramatic increase of 71 percent for those aged 18-25.²⁷ More recent statistics show that reports of suicidal ideation, planning, persistent feelings of hopelessness and sadness in high school students rose consistently from 2009 to 2019. More high school aged teens were injured in a suicide attempt during that period as well.⁷ Other trends from 2009 to 2019 include the rise of electronic devices and digital media as well as declines in sleep which may be contributors to depression and other mood disorders.²⁷ Lack of availability of mental health services is also a concern. Youth who live in urban and suburban areas have been shown to have greater access to mental health resources than teens who live in rural areas.²⁸ When mental health disorders are not properly addressed, the risk for suicide can increase dramatically.^{19,29}

Substance Use Disorder

Substance use is a major predictor of STB in youth.^{30,31} Studies have shown that youth who used substances (tobacco, alcohol, cannabis, MDMA, ketamine) exhibit more suicidal behavior. In general, historically, boys exhibit more serious substance use, for example, using alcohol and drugs in larger quantities, with more frequency, and starting at an earlier age than girls. The association between substance use and suicidal behavior, however, is consistent between males and females.³⁰

Adverse Childhood Experiences (ACEs)

ACEs, including physical, mental, and sexual abuse, physical and emotional neglect, and household dysfunctions such as family mental illness, violence, incarceration, substance use, and divorce, are well documented risk factors for suicide and according to the CDC, are associated with at least five of the ten leading causes of death overall. The higher the number of ACEs experienced, the greater the risk for suicide, and for youth, the risk is greater than in adults. A 2001 study found that an ACE score of 7 or more increased the risk of suicide attempts 51-fold among youth and 30-fold among adults. The study also found that between various forms of abuse, emotional abuse in childhood was the greatest predictor of future suicide attempts and the least addressed by traditional child welfare systems. ACEs increase risk for suicide as well as negative opioid-related outcomes, including overdose. These risk factors due to ACEs are preventable and require urgent attention.³²⁻³⁴

COVID-19 Pandemic

The COVID-19 pandemic has impacted youth STB and mental health. According to CDC data, from April 2020, the proportion of youth mental health-related emergency department (ED) visits increased and remained elevated through October of 2020. Compared with 2019, the proportion of mental health-related visits for youth aged 12-17 years increased approximately 31 percent. Studies have also identified increased rates of suicide ideation and suicide attempts in 2020 during the COVID-19 pandemic as compared with 2019 rates. The increases correspond to times when COVID-related stressors and community responses were heightened. This increase was seen across demographics in the 11-21 age group and based on routine suicide risk screens in a pediatric ED setting.^{35,36}

Stigma

Ample evidence exists related to the negative impact of stigma on mental health. Youth learn stigmatizing attitudes from many sources including parents, peers, and media and start to concretize their attitudes in adolescence. Recognition of mental health stigma as a barrier to care for youth is essential for targeted suicide prevention efforts. In addition, myths around suicide

contribute to stigma. Characterization of people who experience STB as “weak” or “cowardly” perpetuate stigma and can inhibit youth from asking for help.³⁷⁻³⁹

Increased Screen Time and Use of Digital Devices Linked to Depression

The increased use of digital devices and social media can be linked to increases in mental health symptoms, including depression, among youth grades 8-12. Use of social media and digital devices also have an association with increases in youth suicides from 2010 to 2015. A review of several studies on social media/internet use and suicide attempts found consistent associations between heavy internet/social media use and suicide attempts of those under the age of 19.⁴⁰ Depressive symptoms, which have a strong correlation with STB, increased together with screen time and social media use. Moreover, youth who spent less time onscreen and on smartphones and more time on non-screen activities (in person visiting, sports, religious activities, reading) reported fewer depression symptoms and suicidal thoughts.^{40,41}

Bullying and Cyberbullying

Although cyberbullying is a new area of research, several investigators report associations with both emotional and physical variables, including loneliness, anxiety, depression, suicidal ideation, and somatic symptoms. Also linked to cyberbullying is an increased risk of STB and self-harm for victims, and an increased risk of STB for perpetrators.⁴²⁻⁴⁵

The effects of bullying can be magnified and intensified by youths’ access to social media, where the typical number of peers in a school and community circle is now expanded to any youth who has access to the internet and social networking sites. Several examples of tragic stories exist in the media of cases where victims experienced repeated instances of bullying that were widely spread over the internet and social media. Teens left behind messages indicating they felt hopeless that the bullying would stop.⁴⁶

A 2013 review of resources for cyberbullying examined interventions and prevention strategies acknowledge that many resources have been developed, but that there must be more research to determine effectiveness and how best to tailor programs to various school settings.⁴⁷ An online cyberbullying information clearinghouse, The Cyberbullying Research Center, provides guides to state laws on cyberbullying, research, and resources for parents, educators, youth and health care providers on addressing cyberbullying.⁴⁸

Suicide Contagion/Clusters

Suicide clusters consist of episodes of multiple suicides that are greater than what would be typical in a specific location, many times in quick succession, and are more common in young people (<25 years) than adults. Approximately 1-5 percent of youth suicides occur in a cluster after a youth dies by suicide. Suicide contagion, which is triggered by exposure to a death by suicide, can increase the risk of suicide in another and has been shown to be a significant factor in youth STB.⁴⁹ The colloquial term often used for this phenomenon is “copy-cat suicide.” Suicide contagion can result from direct exposure such as a suicide of a family member, friend, or classmate or indirect exposure through media or online reports. Youth are especially sensitive to peers’ thoughts and expressions and may be more impacted by media reporting on suicide, suicide clusters, and exposure to a suicidal peer. A study showing a 28.9 percent spike in youth (ages 10-17) suicide across the United States in the months following the release of the fictional Netflix series “13 Reasons Why,” is an example of the influence of media; the show follows a fictional character who ultimately dies by suicide.⁵⁰

Media depictions or social networking posts that romanticize youth suicide may result in suicide contagion and clusters.⁵¹⁻⁵⁶ Guidelines for the media on responsible reporting on suicides for media are available including a collaboratively produced guide called “Recommendations for Suicide Reporting” and the International Association for Suicide Prevention’s (IASP) guide “Preventing Suicide: A Resource for Media Professionals” outlining numerous “dos and don’ts” for media in reporting on suicide. Among the points of guidance are not using language which sensationalizes or normalizes suicide; not presenting suicide as a constructive solution to problems; avoiding explicit descriptions of the method(s) used in a completed suicide; and using sensitivity when interviewing family and friends of suicide victims.^{57,58}

Developmental Characteristics of Adolescence That Increase Vulnerability

Impulsivity in young people is typical and has been shown to be a factor in their vulnerability to suicidal impulses. Research has found that emotion-relevant impulsivity as well as poor control over emotional reactions are more prevalent in adolescence. A type of emotion-relevant impulsivity, negative urgency, which is a strong and immediate need to avoid unpleasant emotions or physical sensations, is a distinct form of impulsivity and is a strong predictor of problem behaviors and STB.⁵⁹ Underdevelopment of the prefrontal areas of the brain and discordant development in the prefrontal and limbic systems are thought to be linked to teen risk taking and impulsivity. The drive to reward seeking without effective inhibitory controls results in a variety of negative outcomes driven by impulsive behaviors, including STB.^{60,61}

PROTECTIVE FACTORS

Enhancing resiliency and identifying protective factors are important ways to mitigate risks for youth suicide. Protective factors include connectedness to supports such as peers, family, community and social institutions, life skills, coping skills access to behavioral and mental health care, and cultural, religious, or personal beliefs that discourage suicide. There are many resources on ways to enhance resiliency in youth that help mitigate suicide risk including developing a positive identity, and age-appropriate empowerment. The Interagency Working Group on Youth Programs composed of representatives from 21 Federal agencies, has a multitude of web-based resources designed to support positive youth development.⁶²⁻⁶⁴

PREVENTION

School Based Suicide Prevention Programs

School based suicide prevention programs fall generally into several categories; suicide awareness and prevention trainings for school personnel, universal suicide prevention curriculum for all students, and targeted or selected interventions for students who are identified as at risk.

Reviews of research in these areas show that there are some benefits in all these approaches, but there is wide variability in methodology and outcome measurements. Research shows that effectiveness of school-based programs has not been well established yet in terms of impact on primary outcomes (numbers of suicides). More recent reviews of studies on school-based programs literature calls for continued and better research to determine which interventions or which combination of interventions are most effective in preventing suicides.^{65,66}

1 *Screening*

2
3 The U.S. Preventive Services Task Force (USPSTF) examined the evidence to determine whether
4 asymptomatic youth should be screened for suicide risk in their 2013 report and found the evidence
5 to clearly establish risks and benefits to be insufficient.⁶⁷ However, the USPSTF does recommend
6 that primary care clinicians screen youth for depression when appropriate systems are in place to
7 ensure adequate diagnosis, treatment, and follow-up. USPSTF also recommends primary care
8 clinicians provide increased focus for their patients during periods of high suicide risk, such as
9 immediately after discharge from a psychiatric hospital or after an emergency department visit for
10 deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are
11 effective in reducing suicide deaths.⁶⁸⁻⁷⁰ Experts in youth suicide prevention note that effective
12 screening can be a simple conversation beginning with the question: “Are you OK?”⁶⁹

13
14 Currently, there is no recommendation from the American College of Emergency Physicians to
15 institute widespread screening for suicide in Emergency Departments (ED). Some evidence notes
16 that EDs are an ideal place for expanding screening since many youths visit an ED at some point
17 during adolescence. A study using a computerized screening tool, the Computerized Adaptive
18 Screen for Suicidal Youth (CASSY), designed for teens aged 12-17 having an ED visit, accurately
19 predicted a suicide attempt within a three-month period following the ED visit.⁷¹

20 *The Joint Commission*

21
22
23 The Joint Commission has developed seven new and revised elements of performance in
24 accreditation surveys applicable to hospitals, behavioral health care organizations, and accredited
25 critical access hospitals. These new elements are designed to “improve the quality and safety of
26 care for those who are being treated for behavioral health conditions and those who are identified
27 as high risk for suicide.” The revised elements involve environmental risk assessment, use of
28 validated screening tools, evidence-based screening for suicide risk, documentation of overall risk
29 for suicide and mitigation plans, written policies (staff training, reassessment, monitoring high-risk
30 individuals), follow up care, and monitoring whether procedures are effective. It is important to
31 note however, that the new elements of performance for accreditation surveys do not explicitly
32 require that all patients in hospital settings be screened. Despite the allowance for selective
33 screening, some hospital care settings have instituted universal screening of patients and the
34 feasibility of this is an ongoing debate. Other accrediting bodies, specifically the Council on
35 Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF), have
36 also made changes to their standards for facilities related to suicide prevention. The movement in
37 this direction will eventually require some adaptation in health care facilities to these new
38 elements.⁷²

39
40 The Joint Commission recommends several evidence-based screening tools for assessing suicide
41 risk in accredited organizations. They include the Columbia Suicide Severity Rating (C-SSR), the
42 Ask Suicide-Screening Questions (ASQ), and the Suicide Behaviors Questionnaire-Revised (SBQ-
43 R). The Patient Health Questionnaire (PHQ-9) is also recommended as a depression screening tool
44 and scale to determine severity.^{73,74}

45 *Targeted Prevention Efforts*

46
47
48 Statistics note that special attention to targeted prevention efforts could be important for sub-
49 populations of youth that are showing higher risk than others for STB. This includes Native
50 American and Native Alaskan males, Black youth, LGBTQ+ teens, and Latina youth. The National
51 Suicide Prevention Lifeline website devotes a page to resources for Native American and Alaskan

populations. All these youth sub-populations could benefit from targeted prevention efforts that are culturally sensitive and community based.⁷⁵⁻⁷⁷

INTERVENTIONS

Access to Mental Health Care

Reportedly, less than half of young people who have died by suicide had received psychiatric care. Increased access to mental health services is needed in addition to community supports, peer supports, school-based programs, college counseling services and social services designed to prevent youth and young adult suicide.²³ Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a suicide prevention resource list of guides, crisis lines, and prevention programs for children and youth.⁷⁸

Medications

Medications used to treat mental health conditions can alleviate symptoms and hopefully mitigate risk of STB. Evidence exists that treatment with antidepressants can result in lower suicide rates overall.^{79,80} Evidence is also available that indicates lithium and clozapine can directly lower suicidal behavior, however the use of these medications is limited because of the time needed to reach therapeutic levels and the narrow therapeutic index of each of these agents. Anxiolytics, sedative-hypnotics, and some antipsychotic medications can be utilized to decrease agitation, anxiety, distress, insomnia, and other symptoms of psychological distress in an acute situation.^{79,81}

An esketamine nasal spray for depression was recently approved by the US Food and Drug Administration (FDA) for use in adult patients who are contemplating suicide and shows promise for relieving acute suicidality and rapidly improving depressive symptoms. Esketamine can relieve symptoms within 24 hours, as opposed to typical antidepressants which can take up to 3-4 weeks to relieve symptoms. This medication is approved for use in adults only. The American Academy of Child and Adolescent Psychiatry (AACAP) has made a statement reiterating that it is not approved by the FDA for use in pediatric patients and cautioning physicians about off-label use.⁸²⁻⁸⁴ Recently, the National Institute of Mental Health (NIMH), released a research update stating that they are supporting multiple new research projects on ketamine and esketamine as well as transcranial magnetic stimulation (TMS) for safety, efficacy and feasibility in youth and young adults who are acutely suicidal. TMS uses magnets to stimulate specific parts of the brain. Both these interventions could produce rapid decrease in severe suicidal thoughts and feelings.⁸⁵

Specific Psychotherapies

Among psychotherapeutic models, cognitive behavioral therapy (CBT) has the most evidence of effectiveness in youth and adults for a variety of disorders, particularly anxiety and depression.⁸⁶ Internet based CBT (iCBT) has also been studied and consistently shows some efficacy in reducing suicide attempts. iCBT has also shown some efficacy in reducing both SUD and STB in youth and is potentially a highly scalable intervention.^{87,88} Additionally, YST-II, a social support program, shows promise in reducing suicidal ideation in youth following a suicide attempt.⁸⁹ A 2018 report of two independent trials on Dialectical Behavioral Therapy (DBT), showed promise for effectiveness with youth experiencing STB.⁹⁰ More research is needed to fully understand the utility of psychotherapies.

FEDERAL EFFORTS TO REDUCE YOUTH SUICIDE

US Department of Health and Human Services

Office of the Surgeon General. Efforts to prevent adult and youth suicide at the federal level in the United States have been led by the U.S. Surgeon General going back to 2001. The National Strategy for Suicide Prevention (NSSP) was the first organized and comprehensive effort on suicide prevention, with the latest revision done in 2012. The NSSP contains four strategic directions that each include a set of goals and objectives: (1) Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives); (2) Enhance clinical and community preventive services (3 goals, 12 objectives); (3) Promote the availability of timely treatment and support services (3 goals, 20 objectives); and (4) Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives). The NSSP's four strategic directions are meant to work together in a synergistic way to prevent suicide in the nation.

In January of 2021, the Surgeon General released a "Call to Action to Implement the National Strategy for Suicide Prevention," an effort to broaden perceptions of suicide, who is affected, and recognition of the environmental factors as well as individual factors related to suicide risk.^{91,92}

SAMHSA. The National Suicide Prevention Lifeline has been in operation since 2005 and is funded by SAMHSA in partnership with the National Action Alliance for Suicide Prevention (Action Alliance⁹³). The National Suicide Prevention Lifeline is a network of over 160 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. In July 2020, the Federal Communications Commission (FCC) designated the three-digit number 988 for the National Suicide Prevention Lifeline to aid rapid access to suicide prevention and mental health services.^{75,93}

Additionally, SAMHSA recently released an evidence-based guide, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth." This guide is targeted to healthcare professionals and a broad range of stakeholders and details the strategies for addressing suicidal ideation, self-harm, and suicide attempts among youth. The guide highlights psychotherapeutic models that have shown evidence of effectiveness in reducing one or more of the outcomes of suicidal ideation, self-harm (non-suicidal), self-harm (unknown intent), and completed suicides.^{75,89,93}

CDC. The CDC has created a comprehensive technical package of strategies that can be implemented by communities and states that include strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk. Also, the CDC has recently released information showing the increased risk for suicide and negative opioid related outcomes (including overdose) associated with ACEs.^{33,62}

FEDERATION OF MEDICINE EFFORTS

Several medical specialty societies have addressed youth suicide. The American Academy of Pediatrics (AAP) has developed web-based downloadable targeted at teens and their parents/caretakers on mental health as well as identifying suicide risk and creating emotional well-being in teens and children.⁹⁴ Other societies including the American College of Emergency Physicians (ACEP), American Association of Family Physicians (AAFP), the American

Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) all have patient resources, policies, clinical guidance, or public statements addressing depression and identifying imminent risk for STB in youth and adults.^{50,94-97}

A 2021 joint summit on teen suicide co-hosted by the AAP, the American Foundation for Suicide Prevention (AFSP), and the National Institute for Mental Health (NIMH), brought forth several recommendations including the need for early identification of suicide risk, screening/assessment, follow up, and counseling. Other recommendations included the importance of widespread screening for youth seen in the ED for any reason and using a strengths-based and culturally sensitive approach to help youth disclose possible suicidal thoughts and ideation. A focus on prevention efforts, along with better data on their effectiveness for sub-populations (Black, Indigenous/Alaska natives, and LGBTQ youth) was also highlighted. A suicide prevention blueprint document from the summit is scheduled to be available later in 2021.⁹⁸

EMERGING AREAS OF RESEARCH

Medications

New medications for acute STB are being developed and experts have called for increased utilization of existing medications. Leading experts encourage continued research to understand the neurobiology of suicide, including the identification of biomarkers and neuropsychological vulnerabilities associated with acute suicidality.^{79,99} A better understanding of the neuropathophysiology of suicide can assist in the development of new medications for treatment.

Digital Technology and Machine Learning

The National Institutes of Health is funding research into the Mobile Assessment for the Prediction of Suicide (MAPS) as a way of using machine learning to detect suicide risk. These risk prediction algorithms can be embedded in digital devices such as smartphones, tablets, and laptops, and show promise in detection of near and imminent risk.¹⁰⁰

Imminent Risk-Warning Signs

One of the most significant challenges of reducing suicides in youth, as in all demographics, is detecting windows of acute and imminent risk. While many of the risk factors for suicide in young people are understood, the ability to predict imminent risk effectively is lacking. Signs of imminent risk include talking about wanting to die, asking how one will be remembered, seeking out means of suicide, talking about feeling hopeless, expressing feelings of being trapped in unbearable pain, increased misuse of alcohol or drugs, increased agitation, withdrawal, mood dysregulation, and giving away treasured items and belongings.^{19,69}

CONCLUSION

Suicides are increasing among both male and female adolescents, with males using more lethal means such as firearms in completed suicides and attempts. The young Native American/Alaska Native demographic group has the highest number of completed suicides and attempts among all youth. Increases in instances of cyberbullying are an important factor that are associated with youth suicide and require additional attention. Increases in screen time and use of digital devices, internet, and social networking sites have been associated with decreases in time sleeping and increased depression. Additionally, stress and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for all cohorts, including young

people and increased suicidal ideation in some cases. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), SUD, ACEs, or other stressors are present, risk for STB increases.^{29,41,70}

Enhancing physician ability and capacity to screen, identify and respond to risk factors are an important feature of effective suicide prevention for youth, especially for those physicians who are more likely to encounter these patient populations. Physicians should have access to the tools to identify acute and imminent risk and respond with appropriate treatments, linkages to appropriate counseling services, collaboration, and safety planning. Collectively, parents, teachers, peers, physicians, social workers, faith communities, counselors, and others, are critical in identifying when an individual is experiencing a period of imminent risk and assisting in preventing suicide attempts.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That Policy H-60.937 be amended to read as follows:

~~Teen~~ Youth and Young Adult Suicide in the United States

Our AMA:

- (1) Recognizes ~~teen~~ youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Latino, and Indigenous/Native Alaskan youth and young adult populations;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and

- 1 (7) Supports research to identify evidence-based universal and targeted suicide prevention
2 programs for implementation in middle schools and high schools. (Modify Current HOD
3 policy)
4
- 5 2. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be
6 amended by addition to read as follows:
7
- 8 1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread
9 impact of trauma on patients, identifies the signs and symptoms of trauma, and treats
10 patients by fully integrating knowledge about trauma into policies, procedures, and
11 practices and seeking to avoid re-traumatization.
12
- 13 2. Our AMA supports:
14 a. evidence-based primary prevention strategies for Adverse Childhood Experiences
15 (ACEs);
16 b. evidence-based trauma-informed care in all medical settings that focuses on the
17 prevention of poor health and life outcomes after ACEs or other trauma at any time in
18 life occurs;
19 c. efforts for data collection, research, and evaluation of cost-effective ACEs screening
20 tools without additional burden for physicians.
21 d. efforts to educate physicians about the facilitators, barriers and best practices for
22 providers implementing ACEs screening and trauma-informed care approaches into a
23 clinical setting; ~~and~~
24 e. funding for schools, behavioral and mental health services, professional groups,
25 community, and government agencies to support patients with ACEs or trauma at any
26 time in life; and
27 f. increased screening for ACEs in medical settings, in recognition of the intersectionality
28 of ACEs with significant increased risk for suicide, negative substance use-related
29 outcomes including overdose, and a multitude of downstream negative health
30 outcomes. (Modify Current HOD policy)
31
- 32 3. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and
33 Enhancing Access to Mental Health Care,” which recognizes the role of firearms in suicides;
34 encourages the development of curricula and training for physicians with a focus
35 on suicide risk assessment and prevention as well as lethal means safety counseling; and
36 encourages physicians, as a part of their suicide prevention strategy, to discuss lethal
37 means safety and work with families to reduce access to lethal means of suicide, be
38 reaffirmed. . (Reaffirm Current HOD Policy).
39
- 40 4. That Policy H-170.984, “Healthy Living Behaviors,” encouraging state medical societies and
41 physicians to promote physical and wellness activities for children and youth and to advocate
42 for health and wellness programs for children and youth in schools and communities, be
43 reaffirmed. (Reaffirm Current HOD Policy)

Fiscal note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, “Racism” refers to an organized system, rooted in an ideology of inferiority that
2 categorizes, ranks and differentially allocates societal resources to human population
3 groupsⁱ; and
4

5 Whereas, Racism may or may not be accompanied by prejudice at the individual levelⁱ; and
6

7 Whereas, Explicit bias refers to the attitudes or beliefs we have about a person or group on a
8 conscious level and includes the “-isms” such as racism, sexism, etc held by individualsⁱⁱ; and
9

10 Whereas, Implicit or unconscious bias refers to ingrained habits of thought that lead to errors in
11 how we perceive, reason, remember and make decisions and that are unconscious or
12 unintentional and may or may not align with our stated values or beliefsⁱⁱ; and
13

14 Whereas, Microaggressions are brief, commonplace, daily verbal, behavioral, or environmental
15 indignities, whether intentional or unintentional, that communicate hostile, derogatory, or
16 negative slights and insults toward marginalized populations, that implicitly communicate or at
17 least engender hostilityⁱⁱⁱ; and
18

19 Whereas, Microaggressions are very real forms of racism and discrimination, a “persistent daily
20 low hum of racist abuse” that is not minor or micro in how it is experiencedⁱⁱⁱ; and
21

22 Whereas, Microaggressions generate stresses equal to or worse than overt discrimination for
23 underrepresented minority groups^{iv}; and
24

25 Whereas, Recent research shows that regular exposure to perceived discrimination of any kind
26 adversely affects the psychological and physical health of the recipients including depression,
27 anxiety, burnout, trauma response, alcohol use, among others^{iv,v}; and
28

29 Whereas, Patients tend to be in vulnerable states when seeking medical treatment and may be
30 especially susceptible to psychological distress in response to racism or bias; and
31

32 Whereas, Racism in any form is especially detrimental when enacted by health care
33 providers; and
34

35 Whereas, Many instances of racism and bias will likely stay unrecognized unless an ongoing
36 intentional, reflective, and process-oriented practice is implemented; and

Whereas, Examining racism and bias should be viewed as a growth promoting, educational opportunity that has the potential to improve individual interactions and system level practices; therefore be it

RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
 - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
 - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders

1 should work with all stakeholders to ensure safe, discrimination-free work
2 environments within their institutions.

3
4 Tactics to help create this type of organizational culture include:

- 5 • Surveying staff, trainees and medical students, anonymously and confidentially
6 to assess:
 - 7 – Perceptions of the workplace culture and prevalence of discrimination,
8 systemic racism, explicit and implicit bias and microaggressions.
 - 9 – Ideas about the impact of this behavior on themselves and patients.
- 10 • Integrating lessons learned from surveys into programs and policies.
- 11 • Encouraging safe, open discussions for staff and students to talk freely about
12 problems and/or encounters with behavior that may constitute discrimination,
13 including racism, bias or microaggressions.
- 14 • Establishing programs for staff, faculty, trainees and students, such as
15 Employee Assistance Programs, Faculty Assistance Programs, and Student
16 Assistance Programs, that provide a place to confidentially address personal
17 experiences of discrimination, systemic racism, explicit or implicit bias or
18 microaggressions.
- 19 • Providing designated support person to confidentially accompany the person
20 reporting an event through the process. (New HOD Policy)

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

Received: 05/07/21

AUTHORS STATEMENT OF PRIORITY

Racism, or discrimination based on race or ethnicity is responsible for increasing disparities in physical and mental health among Black, Indigenous, and people of color. We feel that this resolution is a top priority for this meeting as it will provide policy for our AMA's new three-year roadmap to embed racial justice and advance health equity within the AMA and our health care system.

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ⁱⁱⁱ Kendi, I. X. (2019). *How to be an antiracist*. New York: One World.

^{iv} Solorzano D, Ceja M, Yosso T. Critical race theory, racial microaggressions, and campus racial climate: the experiences of African American college students. *J Negro Educ*. 2001;69(1/2):60-73.

^v Nadal KL, Wong Y, Griffin KE, Davidoff K, Sriken J. The adverse impact of racial microaggressions on college students' self-esteem. *J Coll Student Dev*. 2014;55(5):461-474.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: AMA Resident/Fellow Councilor Term Limits

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Based on a review of the foundational reports leading to the development of
2 resident/fellow Council and BOT positions, the purpose of these roles is to maintain a resident
3 voice in these bodies and to allow for residents and fellows to both gain experience in the
4 election process and contribute meaningfully to practices of the Councils and BOT; and
5

6 Whereas, BOT Report A at the 1976 AMA Annual Convention, which codified resident and non-
7 voting medical student representation on the Councils with three-year term lengths and a
8 maximum three-term limit for the Council on Medical Education (CME), Council on Medical
9 Service (CMS), Council on Scientific Affairs, and CLRPD; and
10

11 Whereas, Starting at the 1991 Annual Meeting, AMA House of Delegates Resolution 202
12 "Leadership Opportunities in the American Medical Association" called for a review of the AMA
13 Board and Councils to increase the rate of involvement of, "various demographic segments of
14 the AMA physician population in AMA leadership" and the subsequent study period yielded a
15 survey of AMA members showing, "57% favored reducing the maximum tenure of Council
16 members"; and
17

18 Whereas, During the 1996 Interim Meeting of the AMA, the Council on Long Range Planning
19 and Development (CLRPD) presented Report 2 "Terms of Service of AMA Councils" which
20 discussed some of the history of Council term lengths and presented arguments for and against
21 one-, three-, five-, and seven-year terms for AMA Councils, considering "(a) the frequency of
22 campaigns for Council positions, (b) the responsiveness of Council members to the AMA
23 membership, the House and the Board, (c) opportunities to replace Council members whose
24 performance is problematic, and (d) compatibility with the maximum total number of years that
25 individuals can serve on each Council"; and
26

27 Whereas, The CLRPD I-96 Report 2 noted that shorter terms would lead to increased member
28 responsiveness and ease in removal of ineffective Council members, but increase time and cost
29 devoted to campaigns, while shorter terms would be better suited for task-oriented Councils
30 such as the Council on Legislation (COL); and
31

32 Whereas, The RFS has concerns that three-year resident/fellow Council positions would
33 disproportionately inhibit members of specialties with shorter residency training periods from
34 being represented, including Internal Medicine, Emergency Medicine, Pediatrics and Family
35 Medicine; and
36

37 Whereas, Due to current term lengths residents/fellows in longer training programs are
38 unintentionally favored for Council positions; and

Whereas, From 2005-2019 only five residents in three-year residencies without subsequent fellowship positions served as residents on AMA Councils over this 15-year period; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 48 seats (40.0%) were held by residents in three-year residencies, though only 13 seats (10.8%) were held by residents in three-year residencies without subsequent fellowship positions despite 57% of residents matching to a specialty with only 3 years of training; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 65.8% were held by residents either in training programs of 5 or more years or went on to fellowship training totaling 5 or more years during their term; and

Whereas, BOT Report W from 1983 titled "Resident Member of the AMA Board of Trustees" was adopted allowing for the creation of a resident Trustee with a term length of two years and a maximum three-term limit; and

Whereas, The Resident Member of the Board of Trustees has been an effective member of the Board of Trustees despite a term of only two years; and

Whereas, Residents with shorter training periods are disproportionately underrepresented in elected and appointment Council positions thus creating a disparity in representation between primary care residents and specialty-trained ones; and

Whereas, Two-year terms would allow for more opportunities for residents at all training programs, especially those in 3 or 4 year residencies to be represented on AMA councils; therefore be it

RESOLVED, That our American Medical Association amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.

6.5.7 Term.

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 23 years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 23-year term. (Modify Bylaws) and be it further

1 RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion
2 to read as follows:

3 **6.6 Council on Long Range Planning and Development.**

4 **6.6.3 Term.**

5 **6.6.3.2 Resident/Fellow Physician Member.** The resident/fellow physician
6 member of the Council shall be appointed for a term of 23 years beginning at the
7 conclusion of the Annual Meeting provided that if the resident/fellow physician
8 member ceases to be a resident/fellow physician at any time prior to the
9 expiration of the term for which appointed except as provided in Bylaw 6.11, the
10 service of such resident/fellow physician member on the Council shall thereupon
11 terminate, and the position shall be declared vacant.

12 **6.6.5 Vacancies.**

13 **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician
14 member of the Council ceases to complete the term for which appointed, the
15 remainder of the term shall be deemed to have expired. The successor shall be
16 appointed by the Speaker of the House of Delegates for a 23-year term. (Modify
17 Bylaws) and be it further

18
19 RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion
20 to read as follows:

21 **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical**
22 **Education, Council on Medical Service, and Council on Science and Public Health.**

23 **6.9.1 Term.**

24 **6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician
25 member of these Councils shall be elected for a term of 23 years. Except as
26 provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a
27 resident/fellow physician at any time prior to the expiration of the term for which
28 elected, the service of such resident/fellow physician member on the Council
29 shall thereupon terminate, and the position shall be declared vacant.

30 **6.9.3 Vacancies.**

31 **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician
32 member of these Councils ceases to complete the term for which elected,
33 the remainder of the term shall be deemed to have expired. The successor
34 shall be elected by the House of Delegates for a 23-year term. (Modify
35 Bylaws)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The Council on Constitution and Bylaws has indicated support for this policy change, but it requires approval by the HOD. This is crucial to the proper functioning of our RFS leadership and affects elections at this HOD and RFS elections at Interim. Residents and fellows make decisions about leadership and involvement based on time left in training and this change will directly affect our members immediately.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The average age at completion of medical training in the United States is
2 approximately 31.6 years overall¹ and 36.8 years for surgical trainees²; and
3

4 Whereas, Female fertility is known to decrease substantially after age 35,^{3,4} with a nearly 50%
5 drop from the early 20s to late 30s⁵; and
6

7 Whereas, Female physicians have a chance of infertility that is twice that of the general
8 population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years¹; and
9

10 Whereas, The demands of residency increase the risk of pregnancy complications, with a higher
11 rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth
12 restriction among female residents⁶⁻⁸; and
13

14 Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during
15 training⁹ and have concerns about workplace support,¹⁰ which may deter medical students from
16 choosing a career in a surgical or other field with longer and demanding training; and
17

18 Whereas, Approximately one third of program directors have reported discouraging pregnancy
19 among residents in surgical training programs¹⁰; and
20

21 Whereas, Oocyte cryopreservation is an established method of preserving fertility¹¹ that can
22 cost \$10,000 per cycle, often with multiple cycles required, and \$500 per year for storage,¹² in
23 addition to requiring timely injection of ovarian stimulation medications and numerous outpatient
24 visits for cycle monitoring and egg retrieval¹³; and
25

26 Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte
27 cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for
28 several years¹⁴; therefore be it
29

30 RESOLVED, That our American Medical Association support education for residents and
31 fellows regarding the natural course of female fertility in relation to the timing of medical
32 education, and the option of fertility preservation and infertility treatment (Directive to Take
33 Action); and be it further
34

35 RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation
36 and infertility treatment within health insurance benefits for residents and fellows offered through
37 graduate medical education programs (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA support the accommodation of residents and fellows who elect to
 2 pursue fertility preservation and infertility treatment, including the need to attend medical visits
 3 to complete the oocyte preservation process and to administer medications in a time-sensitive
 4 fashion. (Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. This policy applies to current and all future physician trainees.

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.

Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08;
Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the
2 patient's right to accept, modify, and refuse treatment^{1,2}; and
3

4 Whereas, A patient desiring treatment must provide informed consent which can only be given
5 after being informed of their diagnosis, if known, the nature and purpose of any recommended
6 interventions, and the anticipated risks, benefits, and consequences of all options³⁻⁵; and
7

8 Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed
9 consent as "a process of communication whereby a patient is enabled to make an informed and
10 voluntary decision about accepting or declining medical care"⁶; and
11

12 Whereas, A patient's provider is legally and ethically obligated to inform patients as part of the
13 consent process any party who can be reasonably anticipated to be part in their care team
14 including but not limited to residents, nurses, students, and allied health professionals^{3,7}; and
15

16 Whereas, Teaching hospitals historically used the generalized consent form as permission to
17 perform exams of the genital areas, including for educational purposes, without deliberately
18 informing patients of opportunities to limit how any care teams or their members could be
19 involved in their care experience^{4,8-14}; and
20

21 Whereas, In the 1980s, women vocalized demands to be asked for additional explicit consent
22 prior to undergoing educational pelvic exams in the operating room and indicated that doing so
23 without this consent constituted physical assault¹⁵; and
24

25 Whereas, Surveys conducted in 2003 in Philadelphia and 2005 in Oklahoma found medical
26 students were still conducting educational pelvic and rectal exams on anesthetized or
27 unconscious patients without having obtained prior consent to do so^{12,16,17}; and
28

29 Whereas, Educational pelvic exams were historically performed on patients under anesthesia in
30 operating rooms without explicit patient consent, including by medical students not directly
31 involved or not reasonably anticipating to be involved with the patient's ongoing care and when
32 the patient's surgical indications did not warrant a pelvic exam¹⁸; and
33

34 Whereas, Varying attitudes on educating medical students on invasive exams compounded with
35 pressures on students to achieve high academic and clinical marks may contribute to erosion of
36 consideration for scenarios when additional patient consent is indicated^{16,19-24}; and

1 Whereas, The Association of American Medical Colleges (AAMC) and ACOG both emphasize
2 that pelvic exams performed under anesthesia for educational purposes should only be done
3 with a patient's informed consent prior to conducting the exam^{4,24}; and
4

5 Whereas, Various states have passed legislation outlawing educational pelvic exams and/or
6 pelvic exams in general, potentially even when indicated as part of a procedure, on a woman
7 who is anesthetized or unconscious without prior consent to specifically do so^{14,25-32}; and
8

9 Whereas, The Joint Commission maintains that patients may decline participating in elements of
10 clinical training programs, such as working with medical students^{12,33}; and
11

12 Whereas, The AMA Code of Medical Ethics states that patient "participation in medical
13 education is to the mutual benefit of patients and the health care system; nonetheless, patients'
14 (or surrogates') refusal of care by a trainee should be respected in keeping with ethics
15 guidance."³⁴; and
16

17 Whereas, While patients are often open to learner involvement in their care, they may deem
18 scrutiny of more private body parts, particularly when solely for educational purposes, to warrant
19 specific consent beyond the level provided for general care and treatment^{15,35-37}; and
20

21 Whereas, Use of professional standardized patients who teach female pelvic, male
22 genitourinary, and rectal exams have already demonstrated significant value in medical
23 education and further highlight the unnecessary nature of educational genital exams performed
24 without explicit patient consent³⁸⁻⁴⁰; therefore be it
25

26 RESOLVED, That our American Medical Association oppose performing physical exams on
27 patients under anesthesia or on unconscious patients that offer the patient no personal benefit
28 and are performed solely for teaching purposes without prior informed consent to do so
29 (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA encourage institutions to align current practices with published
32 guidelines, recommendations, and policies to ensure patients are educated on pelvic,
33 genitourinary, and rectal exams that occur under anesthesia (Directive to Take Action); and be it
34 further
35

36 RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in
37 educational physical exams (Directive to Take Action); and be it further
38

39 RESOLVED, That our AMA reaffirm policy H-320.951, "AMA Opposition to "Procedure-Specific"
40 Informed Consent." (Reaffirm HOD Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This topic has once again made the news in the last year and is a thorn in the side of our profession. To ensure the continued trust in our profession by our patients and therefore by the public at large, the AMA needs to make a clear statement that unnecessary pelvic exams on sedated patients without their consent is not appropriate. We must not waste the good will and trust we have garnered from the public. This should not be controversial and is already supported by ACOG.

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RELEVANT AMA POLICY

Code of Medical Ethics

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

- (a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

- (i) the diagnosis (when known);
- (ii) the nature and purpose of recommended interventions;
- (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

2.1.6 Substitution of Surgeon

Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the surgeon has an ethical responsibility to:

- (a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.
- (b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines.

2.3.6 Surgical Co-Management

Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:

- (a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
- (b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
- (c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
- (d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
- (e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
- (f) Employ appropriate safeguards to protect patient confidentiality.
- (g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
- (h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
- (i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

7.1.2 Informed Consent in Research

Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:

- (a) Ascertaining that the individual has decision-making capacity.
- (b) Reviewing the process and any materials to ensure that it is understandable to the study population.
- (c) Disclosing:
 - (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
 - (ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
 - (iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
 - (iv) the likelihood of therapeutic or other direct benefit for the participant;
 - (v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
 - (vi) the nature of the research plan and implications for the participant;
 - (vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
- (d) Answering questions the prospective participant has.
- (e) Refraining from persuading the individual to enroll.
- (f) Avoiding encouraging unrealistic expectations.
- (g) Documenting the individual's voluntary consent to participate.

Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:

- (h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.
- (i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
- (j) There is potential for the individual to benefit from the study.

In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

9.2.1 Medical Student Involvement in Patient Care

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment. All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should: (a) Convey to the patient the benefits of having medical students participate in their care. (b) Inform the patients about the identity and training status of individuals involved

in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients. (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated. (d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity. (e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2 Resident & Fellow Physicians' Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals. Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should: (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow. (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients. (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients. Physicians involved in training residents and fellows should: (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity. (e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility. (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students

Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as "patients" are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students' privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:

- (a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
- (b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
- (c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.

- (d) Allow students the choice of whether to participate prior to entering the classroom.
- (e) Never require that students provide a reason for their unwillingness to participate.
- (f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students' overall performance based on their willingness to volunteer as "patients."

Citation: Issued 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951

Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.

Citation: Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10

Informed Consent and Decision-Making in Health Care H-140.989

- (1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
 - (2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
 - (3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.
 - (4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
 - (5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
 - (6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
 - (7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
- Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(JUN-21)

Introduced by: Virginia, New Jersey, District of Columbia, Louisiana, American Association of Clinical Urologists, American Urological Association, Maryland

Subject: Nonconsensual Audio/Video Recording at Medical Encounters

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Fifteen percent of physician-patient visits may be unknowingly recorded with the ubiquitous use of smartphones and other technologies; and

Whereas, Physician malpractice defense attorneys and insurers are anticipating future litigation where patients have recorded telehealth visits without the physicians knowledge or consent; and

Whereas, Thirty-nine states and the District of Columbia conform to a single-party consent rule for recording a conversation between two parties. Eleven states (California, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania, and Washington) require consent of both parties¹; and

Whereas, Audio/video recording of a medical encounter may be of benefit for a patient to recall the pertinent issues and instructions given. Conversely, a covert recording made without the physician or patient's knowledge may erode trust and harm the physician-patient relationship; therefore be it

RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks the AMA to develop policy on nonconsensual audio/video recordings during medical encounters. Studies already show this is occurring at significant rates and will likely increase with the expansion of telehealth during and post-pandemic. Additionally, malpractice defense attorneys are anticipating litigation where patients have recorded telehealth visits without the physician's consent or knowledge. The AMA should take a lead role in developing guidelines for both physicians and their patients on this subject.

References:

¹ Elwyn G, Barr PJ, Castaldo M. Can Patients Make Recordings of Medical Encounters? What Does the Law Say? JAMA. 2017;318(6):513–514. doi:10.1001/jama.2017.7511

RELEVANT AMA POLICY

E-3.1.3. Audio or Visual Recording Patients for Education in Health Care

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:

- (a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
- (b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
- (c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
 - (i) about the purpose of recording, the intended audience(s), and the expected distribution;
 - (ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
 - (iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
 - (iv) that the patient may withdraw consent at any time and if so, what will be done with the recording;
 - (v) that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
- (d) Ensure that the patient has had opportunity to discuss concerns before and after recording.
- (e) Obtain consent from a patient (or the authorized decision maker):
 - (i) prior to recording whenever possible; or
 - (ii) before use for educational purposes when consent could not be obtained prior to recording.
- (f) Respect the decision of a patient to withdraw consent.
- (g) Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.
- (h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.
- (i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
- (j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records.

[AMA Principles of Medical Ethics: I,IV,V,VIII](#)

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

Issued: 2016

E-3.1.4 Audio or Visual Recording of Patients for Public Education

Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a

patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld.

Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).

Physicians involved in recording patients for public broadcast should:

- (a) Participate in institutional review of requests to record patient interactions.
- (b) Require that persons present for recording purposes who are not members of the health care team:
 - (i) minimize third-party exposure to the patients care; and
 - (ii) adhere to medical standards of privacy and confidentiality.
- (c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
- (d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
- (e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
- (f) Inform a patient (or authorized decision maker) who is to be recorded:
 - (i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
 - (ii) about the intended audience(s);
 - (iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
 - (iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
 - (v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
 - (vi) whether the physician was compensated for his participation and the terms of that compensation.
- (g) Ensure that the patient has had the opportunity to address concerns before and after recording.
- (h) Ensure that the patients consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
- (i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patients care) perceives that recording may jeopardize patient care.
- (j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
- (k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record.

AMA Principles of Medical Ethics: I,IV,VII,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended
 Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(JUN-21)

Introduced by: Pennsylvania

Subject: Organ Transplant Equity for Persons with Disabilities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, People with Intellectual and developmental disabilities (IDD) still face discrimination in
2 access of care, specifically regarding barriers of access to transplant surgery, despite federal
3 and local guidelines which protect against discrimination on the basis of disability; and
4

5 Whereas, Transplant centers and medical professionals are unaware or noncompliant with
6 clauses of the Americans with Disabilities Act, Rehabilitation Act, and Affordable Care Act
7 prohibiting discrimination against people with disabilities as is applied to the organ transplant
8 process; and
9

10 Whereas, A 2004 survey found that only 52 percent of people with disabilities who requested a
11 referral to a specialist regarding an organ transplant evaluation actually received a referral,
12 while 35 percent of those “for whom a transplant had been suggested” never even received an
13 evaluation; and
14

15 Whereas, A 2008 survey of pediatric transplant centers found that 43 percent always or usually
16 consider intellectual disabilities an absolute or relative contraindication to transplant due to
17 assumptions and that in some cases, organ transplant centers may categorically refuse to
18 evaluate a patient with a disability as a candidate for transplant; and
19

20 Whereas, Throughout their medical education, Health, Oral Health, and Vision Health providers
21 receive limited training on the special needs of people with IDD related to common problems
22 and delivery of services, and patients report feeling that physicians generally have little
23 understanding of living with a disability; and
24

25 Whereas, If a person has a disability that is unrelated to the reason a person needs an organ
26 transplant, the disability will generally have little or no impact on the likelihood of the transplant
27 being successful and making assumptions regarding post-transplant quality of life for people
28 with IDD violates AMA ethics; and
29

30 Whereas, Congress established the need for an organization, the Organ Procurement and
31 Transplant Network (OPTN), to facilitate the organ transplantation system across the many
32 transplant centers and sources of organ donors in an efficient manner. The effective guidelines
33 for organ allocation do not include disability status in non-discrimination section 5.4.A; and
34

35 Whereas, Titles II and III of the Americans with Disabilities Act (ADA) prohibit discrimination
36 against people with disabilities in all programs, activities and services of public entities and
37 prohibit private places of public accommodation from discriminating against people with
38 disabilities; and

1 Whereas, Section 504 of the Rehabilitation Act of 1973 prohibits federally funded programs
2 including hospitals from denying qualified individuals the opportunity to participate in or benefit
3 from federally funded programs, services, or other benefits, denying access to programs,
4 services, benefits or opportunities to participate as a result of physical barriers, and denying
5 employment opportunities they are otherwise entitled or qualified; and
6

7 Whereas, Section 1557 of the Affordable Care Act prohibits discrimination on the basis of
8 race, color, national origin, sex, age, or disability in certain health programs or activities and
9 ensures physical access for individuals with disabilities to healthcare facilities and
10 appropriate communication technology to assist persons who are visually or hearing
11 impaired; therefore be it
12

13 RESOLVED, That our American Medical Association support equitable inclusion of people with
14 intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD
15 Policy); and be it further
16

17 RESOLVED, That our AMA support individuals with IDD having equal access to organ
18 transplant services and protection from discrimination in rendering these services (New HOD
19 Policy); and be it further
20

21 RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation
22 Network (OPTN) in adding disability status to their nondiscrimination policy under the National
23 Organ Transplant Act of 1984 (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination
26 education materials for healthcare providers related to equitable inclusion of people with IDD in
27 eligibility for transplant surgery. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution recognizes that, although there are existing laws prohibiting discrimination on basis of disability, there is evidence to suggest that people with disabilities remain statistically less likely to receive consultation regarding -- and access to -- organ transplantation. Furthermore, although there is evidence to suggest that those with intellectual disabilities have similar outcomes after transplantation, there may be misperceptions to the contrary within the healthcare system. This resolution aims to have our AMA highlight this discrepancy between law and practice. We feel this is timely because this not only provides an avenue for our organization to advocate for those with disability, but to once again bring to the forefront the challenge of sufficient organ procurement in our nation.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(JUN-21)

Introduced by: Illinois

Subject: Supporting Women and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Racial bias within the healthcare system is a major factor in current healthcare disparities within the United States; and

Whereas, In recent years, there has been a stagnation of the percentage of women and minorities pursuing competitive fellowships within internal medicine; and

Whereas, In academic surgery, 19% are female, and women are less likely to be full professors when controlling for age as well as academic and clinical productivity; and

Whereas, Hispanic and African-American are more underrepresented in clinical academic medicine in current times than they were in 1990; and

Whereas, Women in academic surgery hold fewer positions of leadership on both the departmental and national level; and

Whereas, Chairs of academic surgery departments often rely heavily on internal hires and trusted networks instead of publicly posting positions, while simultaneously reporting difficulty in recruiting women and underrepresented minority applicants for those positions; therefore, be it

RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further

RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce
Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:

1. Identify with group(s) underrepresented and disadvantaged in medicine
2. Are from medically underserved areas
3. Are first generation college graduates

as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely, urgent, and high priority. The link between bias – both implicit and overt – and healthcare disparities has been well documented. Ensuring that individuals who are typically underrepresented in the medical field have support and opportunities throughout their medical education and training to pursue a range of specialties and leadership positions is critical to helping promote equity across the healthcare spectrum.

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
 5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
 6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
 7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
 8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
 9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
 12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
 13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
 14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
- Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19;

Reducing Racial and Ethnic Disparities in Health Care D-350.995

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

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

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

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

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

articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

Citation: (Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

Diversity in Medical Education H-350.970

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

Citation: (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

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

Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.

(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.

(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.

(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.

(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.

(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(JUN-21)

Introduced by: Georgia

Subject: Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, In many states, when a physician retires, has been suspended, or has their license is
2 revoked, patients often have no warning that their physician's office is closed and no ability to
3 obtain their medical records to transfer their care to another physician; and
4

5 Whereas, Laws in many states provides that it is the physician who not only owns the patient's
6 medical records, but also possesses the decision-making ability regarding sharing the records
7 once a patient consents or signs a confidential waiver, except in cases of a subpoena or court
8 order; and
9

10 Whereas, Patients who are aware of their physician retiring are more likely to obtain their
11 medical records upon request, than those patients who have had their physician suspended or
12 revoked; and
13

14 Whereas, The inability of patients to obtain their medical records could be detrimental for
15 chronically ill patients who will need frequent follow-ups, creating increased hospitalizations with
16 increased costs that may have been avoidable; and
17

18 Whereas, There is no AMA policy clearly defining the suspended or revoked physician's
19 responsibilities for patients with their medical records; and
20

21 Whereas, For example, the Texas Medical Board has implemented a policy requiring a
22 suspended or revoked Texas physician to appoint a board-approved custodian tasked with
23 notifying patients within 30 days for the purpose of giving them their medical records; therefore
24 be it
25

26 RESOLVED, That the Council on Ethical and Judicial Affairs be requested to examine
27 E-3.3.1, "Management of Medical Records," with regards to physicians whose license has been
28 suspended or revoked and prepare a report to the 2021 Interim Meeting, including guidance for
29 timely transfer of patient records to the patient or a state medical board-approved custodian.
30 (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The mental and emotional toll of the COVID-19 pandemic has led to increases in substance use disorder that may lead to disciplinary action by medical boards across the country in the coming months. Many states currently have no system for ensuring that medical records are available to a patient where their physician's license has been suspended or revoked and the AMA has no current policy on what should happen to medical records in these instances. This harms these patients because it can lead to a delay in care or a need to repeat diagnostic exams or testing, which can increase costs. It is imperative that a solution is developed now so that ensures that patients can retrieve these records in order to find a new physician to continue their care and a delay in implementing this policy will negatively affect patients and public health in general. The AMA is most appropriate for advocating for this change given the lack of policy in states across the country.

RELEVANT AMA POLICY**3.3.1 Management of Medical Records**

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patients' authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practices' medical records) should:

- (a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
- (b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
 - (i) immunization records, which should be kept indefinitely;
 - (ii) records of significant health events or conditions and interventions that could be expected to have a bearing on the patients' future health care needs, such as records of chemotherapy.
- (c) Make the medical record available:
 - (i) as requested or authorized by the patient (or the patients' authorized representative);
 - (ii) to the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death);
 - (iii) as otherwise required by law.
- (d) Never refuse to transfer the record on request by the patient or the patients' authorized representative, for any reason.
- (e) Charge a reasonable fee (if any) for the cost of transferring the record.
- (f) Appropriately store records not transferred to the patients' current physician.
- (g) Notify the patient about how to access the stored record and for how long the record will be available.
- (h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

AMA Principles of Medical Ethics: IV,V

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

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(JUN-21)

Introduced by: Minority Affairs Section

Subject: Truth, Reconciliation, and Healing in Medicine and Medical Education

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Historical examination of AMA practices and policies have not always served to
2 further equity and justice, but rather categorically exclude or severely limit opportunities for
3 physicians based on race, ethnicity, gender, sexual orientation, capacity, and country of origin,
4 and perpetuate intergenerational harm to historically marginalized and minoritized
5 communities¹⁻⁴; and
6

7 Whereas, AMA archives chronicle decisions by leadership primarily rooted in racism and white
8 supremacy, which have contributed to the systems of power and oppression that structured the
9 realities of health inequities among women, LGBTQ+, Jewish, Black, Indigenous, Latinx, and
10 Asian populations then, and which persist today⁵⁻¹⁴; and
11

12 Whereas, The 1910 “Medical Education in the United States and Canada: A Report to the
13 Carnegie Foundation for the Advancement of Teaching” (a.k.a. “The Flexner Report”)
14 commissioned by the AMA’s Council on Medical Education recommended the closure of five out
15 of the seven historically Black college or university (HBCU) affiliated medical schools existing at
16 the time and described the role of Black physicians as sanitarians and hygienists to “protect”
17 white people from “Black diseases”^{15,16}; and
18

19 Whereas, A recent study in *JAMA Network Open* found that the five HBCU-affiliated schools
20 closed as a result of the Flexner Report’s recommendations would have produced an additional
21 27,773 Black medical graduates in the years between their closure and 2019, increasing the
22 number of Black medical graduates by 29% in 2019 alone¹⁷; and
23

24 Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the
25 areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice
26 through the adoption and implementation of policies, processes, and programs that center
27 equity and antiracism, such as the founding of the AMA Center for Health Equity, recognizing
28 racism as a public health threat, characterizing race as a social construct, reconsidering the
29 clinical application of race, and acknowledging the way communities are policed is a social
30 determinant of health, among others¹⁸; and
31

32 Whereas, In May 2021, the AMA Center for Health Equity released its three-year organizational
33 strategic action plan to embed racial justice and advance health equity within the AMA and
34 across medicine, including “fostering pathways for truth, racial healing, reconciliation and
35 transformation for AMA’s past” through restorative justice^{19,20}; therefore be it

- 1 RESOLVED, That our American Medical Association establish a combined external and internal
2 task force to guide organizational transformation within and beyond the AMA toward restorative
3 justice to promote truth, reconciliation, and healing in medicine and medical education.
4 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY:

As an extension of the AMA Center for Health Equity strategic action plan, this resolution calls for the creation of a task force to strengthen organizational capacity to advance and operationalize equity from within and across medicine through restorative justice. The task force will guide our AMA's transformational work, including historical identification of and accountability for past harmful policies, processes, and archival silence, to promote truth, reconciliation, and healing.

Establishing a task force of this nature is an actionable directive that expands upon and supports ongoing initiatives to dismantle structural racism while presenting an opportunity to evaluate the role of institutions in maintaining these structures.

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RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19

Improving Healthcare of Hispanic Populations in the United States H-350.975

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.

(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.

(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.

(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.

(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.

(6) Promote research into effectiveness of Hispanic health education methods.

(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Citation: (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;

(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;

(3) physicians recognize that race and ethnicity are conceptually distinct;

(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-

designations by research participants;

(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;

(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and

(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

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

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Citation: BOT Action in response to referred for decision Res. 602, I-15;

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

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

Reducing Racial and Ethnic Disparities in Health Care D-350.995

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

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

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

of professionalism and professional obligations in efforts to reduce health care disparities.

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

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

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953

Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

Citation: Res. 405, A-18

Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991

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

Citation: (Res. 409, A-09; Appended: Res. 416, A-11)

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

Our AMA:

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

Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:

- (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;

- (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
 - (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
 - (4) Response to inquiries and concerns of minority physicians and medical students; and
 - (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
- Citation: CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869

Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.

Citation: Res. 914, I-07; Modified: BOT Rep. 22, A-17

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Citation: Res. 001, A-18

Support of Human Rights and Freedom H-65.965

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

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18;

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.

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

3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.

4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.

5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20;

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.

2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.

3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

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

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmation A-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19;

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

Citation: CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16;

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

Alignment of Accreditation Across the Medical Education Continuum H-295.862

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
 - a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
 - b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
 - c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
 All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
 - a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
 - b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

Citation: (CME Rep. 4, A-14; Appended: CME Rep. 10, A-15)

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.

Citation: Res. 910, I-16; Appended: Res. 410, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(JUN-21)

Introduced by: Young Physicians Section

Subject: Increasing Public Umbilical Cord Blood Donations in Transplant Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Allogeneic stem cell transplants continue to save lives, reaching over 20,000
2 procedures per year in the United States¹; and
3

4 Whereas, Allogeneic stem cell therapy can only save lives in patients matched with a
5 donor; and
6

7 Whereas, Umbilical cord blood stem cells offer clinical advantages over traditional stem cell
8 transplants in select scenarios²; and
9

10 Whereas, Umbilical cord blood transplants increase the ethnic diversity of patients eligible for
11 transplant³; and
12

13 Whereas, The American Society for Transplantation and Cellular Therapy⁴, the American
14 College of Obstetricians and Gynecologists⁵, and the American Academy of Pediatrics⁶ all
15 support public (altruistic) donation of cord blood when possible; and
16

17 Whereas, Public donation of cord blood is difficult if the birthing hospital does not support public
18 cord donation; and
19

20 Whereas, Very few hospitals support in-house public cord blood donation infrastructure - only
21 two hospitals in Ohio, and three each in New York and Massachusetts⁷; and
22

23 Whereas, Many hospitals which provide comprehensive care including both childbirths and stem
24 cell transplants are notably absent from these lists; therefore be it
25

26 RESOLVED, That our American Medical Association encourage all hospitals with obstetrics
27 programs to make available to patients and reduce barriers to public (altruistic) umbilical cord
28 blood donation (Directive to Take Action); and be it further
29

30 RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all
31 states. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for support for tying an option for public cord blood donation on Labor and Delivery to transplant programs quality metrics at the same hospital. Though this is important, this impacts a small number of physicians and is not a time-sensitive issue. Specialty organizations may also be suited to making this push for policy. Therefore, we feel this is a low priority resolution.

References:

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RELEVANT AMA POLICY

Code of Medical Ethics. 6.1.5 Umbilical Cord Blood Banking

Transplants of umbilical cord blood have been recommended or performed to treat a variety of conditions. Cord blood is also a potential source of stem and progenitor cells with possible therapeutic applications. Nonetheless, collection and storage of cord blood raise ethical concerns with regard to patient safety, autonomy, and potential for conflict of interest. In addition, storage of umbilical cord blood in private as opposed to public banks can raise concerns about access to cord blood for transplantation.

Physicians who provide obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples.

Physicians who participate in collecting umbilical cord blood for storage should:

- (a) Ensure that collection procedures do not interfere with standard delivery practices or the safety of a newborn or the mother.
- (b) Obtain informed consent for the collection of umbilical cord blood stem cells before the onset of labor whenever feasible. Physicians should disclose their ties to cord blood banks, public or private, as part of the informed consent process.
- (c) Decline financial or other inducements for providing samples to cord blood banks.
- (d) Encourage women who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:
 - (i) in view of the cost of private banking and limited likelihood of use;
 - (ii) to help increase availability of stem cells for transplantation.
- (e) Discuss the option of private banking of umbilical cord blood when there is a family predisposition to a condition for which umbilical cord stem cells are therapeutically indicated.
- (f) Continue to monitor ongoing research into the safety and effectiveness of various methods of cord blood collection and use.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(JUN-21)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine
and Medical Professionalism

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as
2 well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or
3 the right to keep hair in an uncut or untrimmed manner ¹; and
4

5 Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for
6 cultural purposes and serves as a way to express values of a demographic group or particular
7 society for religious, spiritual, or gender identification ²; and
8

9 Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for
10 racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural
11 headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious
12 association ³⁻⁶; and
13

14 Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate
15 against any individual based on an "... individual's race, color, religion, sex, or national origin",
16 and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also
17 unintentional discrimination on the enumerated proscribed ground ⁷; and
18

19 Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part
20 of medical professionalism standards tend to be euro-centric and penalize those with non-euro-
21 centric phenotypical features and/or culture ^{8,9}; and
22

23 Whereas, In 2019, the State of California and New York City have passed laws to address hair
24 discrimination within the workplace through the CROWN Act (SB 188) and the NYC
25 Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the
26 Basis of Hair ^{1,3}; and
27

28 Whereas, United States Armed Forces have repealed several bans on natural hair and cultural
29 headwear in the workplace (Army Regulation 670-1, Section 3-2) ¹⁰; and
30

31 Whereas, Qualitative analysis of minority resident physicians has revealed the additional
32 challenges to embracing their racial identities in a professional setting results in less job
33 satisfaction and more susceptibility to burnout ¹¹; and
34

35 Whereas, Studies show "a positive association between physician-patient racial/ethnic
36 concordance and patients' receiving preventive care, being satisfied with their care overall..." ¹²;
37 and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace (New HOD Policy).

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to build upon recently adopted AMA policy on racism in medicine and promotion of health equity, both of which are major priorities.

Natural hair and cultural headwear can be a proxy for racial discrimination and therefore should be protected from discrimination tactics. It has been demonstrated through the establishment of policies and laws in California, New York City, and (most recently) Cincinnati that current discrimination policies do not adequately address this specific form of discrimination. This is an incredibly common issue experienced by many of our peers in the medical community, particularly minority women. This creates an unjust educational and professional environment, as repeat chemical or heat hair treatments are costly, time-consuming, and incredibly damaging to hair and skin. This practice impedes the collective advancement of minority women in medicine and healthcare. This timely resolution would address a critical gap in existing AMA policy. By the AMA stating explicitly that natural hair and cultural headwear is professional and accepted in the medical field, it will change the culture and attitude around this topic.

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (BOT Rep. 27, A-19)

Support of Human Rights and Freedom H-65.965

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

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions,

with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher. In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unflinching honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90, Reaffirmed by CME Rep. 9, A-98, Reaffirmed: CME Rep. 2, I-99, Modified: BOT Rep. 11, A-07, Reaffirmed: CME Rep. 9, A-13)

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. (Res. 307, A-09, Appended: Res. 955, I-17)

Eliminating Religious Discrimination from Residency Programs H-310.923

Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. (CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16)

Discrimination Against Physicians by Patients D-65.991

Our AMA will study: (1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests. (Res. 018, A-18)

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community,¹⁻⁴ including disproportionate rates of incarceration,⁵⁻⁷ residential segregation,⁸ and unfair labor and employment policies; and

Whereas, Toxic stresses of racism⁹, incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior¹⁰, disease, and early death in minority children^{11,12}; and

Whereas, The racial wealth gap in the United States has increased dramatically, as households with black children hold just one cent for every dollar held by households with non-Hispanic white children as of 2016^{13,14}; and

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes^{15,16}; and

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities,^{17,18} which are correlated with positive health outcomes,^{19,20} for the African American community; and

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations^{14,21}; and

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities²¹; and

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including \$5.5 million in direct compensation, free college education to survivors, a formal apology from the city, and education on police torture in public schools²²; and

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities^{14,23}, and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989²¹; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes^{23–25}; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over \$60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past^{26,27}; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation^{28–30}; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population^{14,30,31}; and

Whereas, The black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly black medical schools after the 1910 publication of the Flexner Report³¹; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships^{32,33}; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders³³; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our AMA made health equity and addressing racism in medicine some of its top priorities over the past year. This resolution builds upon this body of policy by asking our AMA to support the study of reparations as a means to reduce racial inequalities.

The historical exclusion of African American physicians into the AMA led to the Creation of the National Medical Association in 1895, and subsequently the Student National Medical Association in 1964. Their creation paved the way for African-American physicians and medical students to formally enter the realm of organized medicine, given that they were otherwise barred from joining previously established organizations such as the AMA. The NMA and SNMA allowed for organized support of addressing the needs of the underserved and to developing culturally competent and socially conscious physicians. Given the long historical context of this resolution, supported by the July 10th 2008 AMA apology that states in part "past history of racial inequality toward African-American physicians, and shares its current efforts to increase the ranks of minority physicians and their participation in the AMA" - The timing of this resolution is sound. We have a duty to study how reparations within the field of medicine would impact our Black patients and how we as an organization might participate in that reparative process to reduce racial health inequity.

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority

membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972

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

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

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

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

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA

supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Racial and Ethnic Disparities in Health Care D-350.995

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(JUN-21)

Introduced by: Medical Student Section
GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Opposition to the Criminalization and Undue Restriction of Evidence-Based
Gender-Affirming Care for Transgender and Gender-Diverse Individuals

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Gender affirmation refers to the process of recognizing one's gender identity through
2 social, psychological, and legal methods and may include medical interventions such as
3 pubertal suppression, hormone therapy, and surgery¹; and
4

5 Whereas, Gender-affirming healthcare refers to care that is sensitive, responsive, and affirming
6 to transgender patients' gender identities and/or expressions¹; and
7

8 Whereas, Transgender and gender-diverse (TGD) youth are at greatly increased mental health
9 risks: for example, more than 50% of female-to-male transgender adolescents reported an
10 attempted suicide, compared to 14.1% among all adolescents²; and
11

12 Whereas, TGD youth given gender-affirming treatment had lower lifetime odds of suicidal
13 ideation as compared to those who desired but did not receive such treatment, decreasing rates
14 of mental illness to those comparable to cisgender youth³⁻⁵; and
15

16 Whereas, Even though it is currently legal for physicians to provide gender-affirming care for
17 TGD youth and adults, these groups already face significant barriers to receiving this care⁶⁻⁷;
18 and
19

20 Whereas, The World Professional Association for Transgender Health (WPATH) and Endocrine
21 Society suggest beginning medical pubertal suppression at Tanner Stage 2, which may even
22 occur before the age of 10, and state that refusing timely gender-affirming care might prolong
23 gender dysphoria⁸⁻⁹; and
24

25 Whereas, In 2020, at least eight state legislatures, including Missouri, Florida, Illinois,
26 Oklahoma, Colorado, South Carolina, Kentucky, and South Dakota, have introduced legislation
27 that would criminally punish physicians who follow evidence-based practices for treating
28 adolescents with gender dysphoria¹⁰; and
29

30 Whereas, AMA policy H-65.965, Support of Human Rights and Freedom, opposes any
31 discrimination based on an individual's sex, sexual orientation or gender identity¹¹; and
32

33 Whereas, In May 2019, six leading medical organizations - the American Academy of Family
34 Physicians, American Academy of Pediatrics, American College of Obstetricians and
35 Gynecologists, American College of Physicians, American Osteopathic Association, and
36 American Psychiatric Association - issued a joint statement detailing opposition to "efforts in

1 state legislatures across the United States that inappropriately interfere with the patient-
 2 physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in
 3 some cases, even criminalize physicians who deliver safe, legal, and necessary medical care”¹²;
 4 and

5
 6 Whereas, Our AMA has spoken out on numerous occasions in opposition to state legislatures
 7 attempting to undermine the patient-physician relationship either through criminalizing
 8 healthcare decision-making or through censoring the content of physicians’ counseling on topics
 9 like firearm safety or family planning options; and

10
 11 Whereas, Our AMA has previously determined it prudent to specifically oppose the
 12 criminalization of medical care to populations that have been politicized in state legislatures,
 13 such as policy H-440.876, which supports the right of physicians to provide medical care to
 14 undocumented immigrant patients without fear of retribution; and

15
 16 Whereas, Our AMA policy D-160.999 “Opposition to Criminalizing Healthcare Decisions” seeks
 17 to educate physicians regarding the continuing threat posed by the criminalization of healthcare
 18 decision-making and the existence of our model legislation “An Act to Prohibit the
 19 Criminalization of Healthcare Decision-Making”, and the timely introduction of this resolution in
 20 the House of Delegates (HOD) further serves this purpose; therefore be it

21
 22 RESOLVED, That our American Medical Association amend policy H-185.927, “Clarification of
 23 Medical Necessity for Treatment of Gender Dysphoria,” by addition and deletion to read as
 24 follows:

25
 26 Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
 27 Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria,
 28 as determined by shared decision making between the patient and physician, are
 29 medically necessary as outlined by generally-accepted standards of medical and
 30 surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to
 31 provide medically necessary care for gender dysphoria; and (3) opposes the
 32 criminalization and otherwise undue restriction of evidence-based gender-affirming
 33 care. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR’S STATEMENT OF PRIORITY

The AMA has long advocated for our LGBTQ+ patients and colleagues. This resolution seeks to amend policy H-185.927 and direct the AMA to active oppose efforts blocking the delivery of safe, gender-affirming care by physicians. While we recognize the fantastic advocacy that AMA has already carried out to defend physician provision of gender-affirming care, this language empowers us to engage in state-specific advocacy driven by state medical associations, who may not have the existing resources or background to adequately advocate against these new bills. 2021 is unlikely to be the endpoint for these attacks, and this language demonstrates AMA's commitment to LGBTQ health equity in no uncertain terms.

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RELEVANT AMA POLICY**Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991**

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

violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmed, A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

BOT Rep. 33, A-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would **criminalize** or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.

2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Res. 402, A-12

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive

and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Res. 010, A-17

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of Res. 001, I-16; Reaffirmation: A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122, A-08; Modified: Res. 05, A-16

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

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

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

Res. 05, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(JUN-21)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and
Detention Centers

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people
2 who have been accused and/or convicted of a crime¹; and
3

4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,
5 people awaiting trial or sentence, or young offenders for short periods of time²; and
6

7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual
8 confined to a cell for 22 to 24 hours per day, routinely used as a punishment for disciplinary
9 violations in correctional facilities and detention centers³; and
10

11 Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as
12 not standing up for headcount or not returning a food tray^{3,4}; and
13

14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means
15 of reprisal for reporting unsafe and unsanitary conditions^{5,6}; and
16

17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of
19 infectious disease⁷; and
20

21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary
23 measure overseen by medical professionals who treat prisoners with compassion and provide
24 prisoners resources to aid their recovery⁷; and
25

26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around
27 60,000 people, currently reside in some form of solitary confinement⁸; and
28

29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average
30 of \$75,000 per prisoner per year⁹; and
31

32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are
33 offered few or no educational, vocational, or rehabilitative programs¹⁰; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes¹¹⁻¹³; and

Whereas, There is a strong association between solitary confinement and self harm, for instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions^{4,13,14}; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders¹⁴; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality than those who do not¹⁵; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses¹⁶; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services^{12,13}; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement¹⁷; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism^{14,18-20}; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety¹⁹; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates²⁰; and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement⁸; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women²¹; and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18^{22,23}; and

Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures²³; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is “cruel, inhuman or degrading treatment or punishment”²³; and

Whereas, The Mandela Rules further state that “solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review”²³; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and should be considered cruel and unusual punishment and a human rights violation²⁴; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons¹⁸; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence¹⁸; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%¹⁹; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence²⁵; and

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection¹⁸; and

Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City²⁶; and

Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:

Reducing ~~Opposing~~ the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length, ~~with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for a short a time as possible;~~ and (2) ~~while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ and (3) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections for marginalized and underserved populations, including the incarcerated. This resolution denounces the use of solitary confinement, which evidence has shown to threaten the physical and mental health of incarcerated and detained persons. This resolution explains that humane alternatives are available to ensure safety and prevent violence. Our delegation has worked to solicit review from advocacy and staff to ensure the issue is timely, addresses a gap in policy, and without substantial concerns on feasibility or actionability.

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Res. 412, A-18.

Solitary Confinement of Juveniles in Legal Custody H-60.922

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

Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Res. 001, A-18.

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17.

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

BOT Rep. 24, A-18.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Sex work entails the provision of sexual services for money or goods, while sex
2 trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a
3 person for the purpose of a commercial sex act^{34,35}; and
4

5 Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter,
6 food, or money; survival sex is considered a subset of “sex work” since it does not involve the
7 force, fraud, or explicit coercion defined in sex trafficking; and
8

9 Whereas, Consent is defined by the federal government as a freely given agreement to the
10 conduct at issue by a competent person, and consent is not constituted by lack of verbal or
11 physical resistance; and
12

13 Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—
14 often problematically falls under the term “consensual” sex work; thus, consent in the realm of
15 sex work falls on a spectrum, rather than a binary definition; and
16

17 Whereas, Globally, the three major policy approaches to sex trade regulation are
18 criminalization, full and partial decriminalization, and legalization; the US primarily utilizes
19 criminalization; and
20

21 Whereas, Criminalization of sex work is associated with higher prevalence of unsafe practices,
22 such as not using condoms, higher rates of STIs, lower likelihood of seeking healthcare for
23 illness or injury related to sex work, and greater likelihood of violence and rape of the individuals
24 selling sex;^{13-18,20,23}; and
25

26 Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers
27 were four times more likely to report mental health issues, possibly due to increased risks that
28 come with illegal sex work such as assault and arrest¹⁶; and
29

30 Whereas, Because sex work is criminalized in the United States, many sex workers struggle to
31 obtain health insurance, leading to the majority being uninsured and paying out of pocket for
32 healthcare¹⁸; and
33

34 Whereas, A systematic review of the literature estimates that 15-20% of men in the United
35 States have paid for sex at least once¹⁹; and

1 Whereas, In 2016, over 33,000 people, many of whom were parents, were arrested for
2 prostitution and commercial vices in the United States, putting their children at an increased risk
3 for depression, anxiety, antisocial behavior, drug use, and cognitive delays^{21,22}; and
4

5 Whereas, The threat of potential arrest forces sex workers to move their business into sparsely-
6 populated and poorly-patrolled areas such as rural or industrial settings, where pimps and
7 clients can perpetrate violence with impunity²⁶; and
8

9 Whereas, Criminalization of sex work is associated with higher rates of sexual harassment,
10 rape, and violence perpetrated by police against people selling sex^{2,24,25,28}; and
11

12 Whereas, Individuals who sell sex for survival are often those from among the most vulnerable
13 communities, such as undocumented immigrants, minority ethnic populations, the economically
14 marginalized, homeless populations and especially homeless LGBTQ populations, and
15 transgender people;²⁸, and
16

17 Whereas, In a nationwide study 12% of trans women reported earning income through sex
18 work, with higher rates among trans women of color, and 77% of these women reported intimate
19 partner violence, 72% reported sexual assault, and 86% reported police harassment; and
20

21 Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work
22 Projects, Amnesty International, and Human Rights Watch all recommend decriminalization of
23 consensual sex work to improve access to health care for high risk populations, with the WHO
24 specifying that decriminalization would help reduce HIV incidence¹⁻³; and
25

26 Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex,
27 acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely-followed
28 system of partial decriminalization and is employed in Sweden, Norway, Iceland, France,
29 Ireland, Northern Ireland, Canada, and Israel³⁶; and
30

31 Whereas, In the Equality Model, people currently selling sex are offered voluntary participation
32 in social services, and people found to be buying sex are offered voluntary participation
33 programs to help them stop buying sex³⁶; and
34

35 Whereas, Partial decriminalization strategies such as the Equality Model are associated with a
36 markedly lower rate of human trafficking, while full decriminalization and legalization are
37 associated with increases in human trafficking to meet the increased demand for commercial
38 sex, as well as increases in organized crime^{36,38,39}; and
39

40 Whereas, Transition from criminalization to the decriminalization of the sale of sex in the
41 Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a
42 comparatively lower number of persons trafficked compared to surrounding nations using other
43 policy systems⁴⁰; and
44

45 Whereas, Though partial decriminalization will not eliminate all the risks of sex work, it will
46 empower sex workers to self-organize and collaborate with law enforcement⁴¹; and
47

48 Whereas, Among the various systems of prostitution policy, only the Equality Model has
49 resulted in net decreases of human trafficking, violence against sex workers, and STI rates
50 among the general population; therefore be it

1 RESOLVED, That our American Medical Association recognize the adverse health outcomes of
2 criminalizing consensual sex work (New HOD Policy); and be it further

3
4 RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex
5 in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel
6 keeping; and 3) support the expungement of criminal records of those previously convicted
7 of sex work, including trafficking survivors (New HOD Policy); and be it further

8
9 RESOLVED, That our AMA support research on the long-term health, including mental health,
10 impacts of decriminalization of the sex trade. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections for marginalized and underserved populations. This resolution asserts that sex work a widely misunderstood and neglected public health crisis that demands the attention of our AMA. It demonstrates the net positive public health benefits of decriminalizing sex work including stronger family units; safer work environments; decreased illegal sex tracking; improved access to healthcare by otherwise marginalized individuals; and fewer arrests of otherwise "normal," hard working citizens simply trying to live. These results have been demonstrated in United Kingdom, Australia, Belgium, Argentina, Denmark, Israel, the Netherlands, New Zealand, Spain, Switzerland, Singapore, and even in our own US state of Nevada. Clearly, sex work, in the same vein as drug use and abortion, has counterintuitive solutions that result in a better world for us all.

Our AMA has been leading the charge with evidence based solutions to many controversial issues in the past decades, and we believe that sex work is next. We urge this resolution's consideration and look forward to seeing the AMA join the WHO, UNFPA, UNAIDS, and many first world countries in destigmatizing what has long been a mislabeled immorality and improving the lives of many marginalized individuals.

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RELEVANT AMA POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Res. 009, A-17

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958

Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and “best practices”. Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.

Res. 14, A-15; Modified: Res. 003, I-17

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of “treatment as prevention,” and the need for linkage of newly HIV-positive persons to clinical care and partner services.

CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

Global HIV/AIDS Prevention H-20.898

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.

Res. 439, A-08; Modified: Res. 003, I-17

Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
 - a. An assessment tool for health care professionals
 - b. Online training in recognizing and responding to human trafficking in a health care context
 - c. Speakers and materials for in-person training
 - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

BOT Rep. 20, A-13; Appended: Res. 313, A-15

Human Trafficking / Slavery Awareness D-170.992

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Res. 015, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(JUN-21)

Introduced by: Medical Student Section

Subject: LGBTQ+ Representation in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, The Association of American Medical Colleges (AAMC) has defined
2 underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are
3 underrepresented in the medical profession relative to their numbers in the general population"
4 since 2003, with an overarching goal to advocate for population parity¹; and
5

6 Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering
7 diversity as referring solely to race and ethnicity is too narrow and that broadening the definition
8 of diversity would help to encompass sexual orientation, religion, geography, disability, age,
9 language, and gender identity²; and
10

11 Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their
12 sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as
13 transgender; the last two components of the acronym can stand for queer or questioning and
14 are meant to encompass all identities that are not heterosexual or cisgender³; and
15

16 Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation,
17 gender identity, or both of these identity aspects³⁻⁵; and
18

19 Whereas, The National Institutes of Health (NIH) formally designated sexual and gender
20 minorities (SGMs) as a health disparity population for NIH research due to mounting evidence
21 that SGM populations have less access to healthcare and higher burdens of diseases such as
22 depression, cancer, and HIV/AIDS⁶; and
23

24 Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of
25 heterosexual healthcare providers reported moderate to strong implicit preference for
26 heterosexual patients over homosexual patients, while gay and lesbian providers showed more
27 implicit preference in favor of homosexual patients⁷; and
28

29 Whereas, In 2015, the American College of Physicians emphasized the need for "programs that
30 would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer
31 support to LGBT medical students, residents, and practicing physicians"⁸; and
32

33 Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+
34 people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth
35 have experienced social ostracism because of their LGBTQ+ identity⁹; and

Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable¹⁰⁻¹²; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"¹³; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

Fiscal note: Moderate - between \$5,000 - \$10,000

Date received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Evidenced-based advocacy and support for our LGBTQ+ colleagues have been cornerstones in the AMA's operations and initiatives. This resolution highlights the paucity and lack of comprehensive, repeated data representing LGBTQ+ demographic data both in the general population and in medicine. It further asserts that our AMA should advocate for initiatives that intentionally recruit and reaffirm our LGBTQ+ colleagues from the start of their training in medicine. Our delegation therefore urges the consideration of this resolution by the HOD for proper discussion and review of all stakeholders within our organization.

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RELEVANT AMA POLICY:

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322 – Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. Res. 313, A-09 Modified: CME Rep. 6, A-11

Strategies for Enhancing Diversity in the Physician Workforce H-200.951 - Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06

Reaffirmed: CME Rep. 7, A- 08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16

Medical Staff Development Plans H-225.961 – All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria

related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. 2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878 – Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(JUN-21)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Race is a self-identified social construct that results in differential treatment of groups
2 that leads to social inequity on people's health^{1,2}; and
3

4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-
5 identification of their origin or descent, "roots," heritage, or place where the individual or their
6 parents or ancestors were born³; and
7

8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);
9 and
10

11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and
13 Chicano/a/x" have been used interchangeably with race in case report⁴⁻⁷; and
14

15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of
16 origin and cultural heritage, constructs which can change over time^{8,9}; and
17

18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based
19 consensus is necessary for optimal use of self-identified race as well as geographical
20 ancestry¹⁰; and
21

22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine¹¹;
24 and
25

26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency
29 department¹²; and
30

31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in
32 2015, there was substantial variation between states in administrative data misclassification of
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native
34 beneficiaries¹³; and
35

36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the
37 62 studies provided complete descriptions of their study populations¹⁴; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity¹⁵; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results¹⁶; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients¹⁶; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology¹⁶⁻¹⁸; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women⁴; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women¹⁹; and

Whereas, It was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences⁴; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care²⁰; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, Our AMA “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias²¹; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The current momentum with respect to the discussion of race and ethnicity necessitates a foundation on the definition, and our AMA witnessed this first hand from the incident with the JAMA podcast. Our AMA has already established policy discerning that race and ethnicity are conceptually distinct. Therefore, it is in the jurisdiction of our AMA to support scientific data that correctly aligns with the related but distinct nature of these words. The resolved clauses of this resolution are supported by H-350.974, specifically "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."

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RELEVANT AMA POLICY

Code of Medical Ethics 7.1.5 – Misconduct in Research

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
 - (b) Resolve charges expeditiously.
 - (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
 - (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
 - (e) Maintain accurate and thorough documentation throughout the process.
 - (f) Maintain the highest degree of confidentiality.
 - (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.
- Issued: 2016

Code of Medical Ethics Opinion 8.5 – Disparities in Health Care

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

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

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.

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

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

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

BOT Action in response to referred for decision: Res. 602, I-15

Improving the Health of Black and Minority Populations, H-350.972:

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

Reducing Racial and Ethnic Disparities in Health Care, D-350.995:

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

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

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

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

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

Strategies for Eliminating Minority Health Care Disparities, D-350.996:

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee Amendments to Constitution and Bylaws

1 Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC)
2 or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to
3 dissuade women from seeking legal abortion to terminate pregnancy¹; and
4

5 Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive
6 medical facilities with licensed clinical professionals despite offering only select services,
7 providing misinformation regarding abortion and contraception, and being largely staffed by
8 volunteers instead of licensed care providers^{2,3}; and
9

10 Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable
11 populations like minority and low-income women, which are the target population pursued by
12 Pregnancy Counseling Centers⁴; and
13

14 Whereas, Our AMA submitted an amicus brief to the U.S. Supreme Court in the case titled
15 *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, in support of
16 California's 2016 Reproductive Freedom, Accountability, Comprehensive Care and
17 Transparency (FACT) Act on the basis of "medical ethics and a patient's right to informed
18 consent"; and
19

20 Whereas, California's FACT Act would have required all licensed medical facilities to publicly
21 post information about affordable abortion and contraception services offered on their premises
22 and required all unlicensed CPCs to disclose that they were not licensed medical clinics⁵⁻⁷; and
23

24 Whereas, The public health repercussions that these entities pose by influencing women's
25 reproductive health decisions is well established by putting women at greater risk when they are
26 interrupted from seeking abortions in a timely manner, therefore subjecting them to the
27 increased risk associated with late term abortions or unsafe abortions⁸; and
28

29 Whereas, Pregnancy Counseling Centers perpetuate decreased prenatal care, substance
30 abuse, preterm births, and increased incidence of negative physical and mental outcomes of
31 babies that are born to women with unintended pregnancies⁸; and
32

33 Whereas, Our AMA recognizes the unethical practices utilized by Pregnancy Counseling
34 Centers in the Journal of Medical Ethics, such as providing misleading and false information that
35 falls outside of medical standards⁹; and
36

37 Whereas, These practices can cause women to miss abortion law cutoffs, receive dangerous
38 late-stage abortions, and obstruct general access to abortion, all of which violate the ethical
39 standards of beneficence, respect for autonomy, nonmaleficence, and justice⁹; and

1 Whereas, Pregnancy Counseling Centers often use federal funds from programs like Temporary
2 Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title
3 X family planning funding programs to fund their clinic's services despite only offering a limited,
4 and often incomplete, number of services^{10, 11}; and
5

6 Whereas, Pregnancy Counseling Centers can be funded by anti-choice organizations despite
7 not disclosing this connection, such as profits made by "Choose Life" license plates which fund
8 Pregnancy Counseling Centers in 32 states¹²; and
9

10 Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as
11 of 2015, \$60 million in federal abstinence and marriage promotion funds have gone to
12 Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling
13 Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to
14 Pregnancy Counseling Centers^{13, 14}; and
15

16 Whereas, A survey of 254 websites that identify individual Pregnancy Counseling Centers
17 revealed only 85 contained information on male condoms or sexually transmitted infections
18 (STIs), and of these 85, 63.5% discouraged condom use by providing negative facts about
19 condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or
20 videos of youth on their homepage to target younger populations¹⁵; and
21

22 Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on
23 search engine results, billboards, and buses near abortion clinics with abortion-related terms
24 while hiding their agenda to dissuade women from seeking legal abortions¹⁶; and
25

26 Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful
27 tactics to dissuade women from seeking legal abortion such as wearing white coats although
28 they hold no medical training, failing to disclose they are not a medical facility, expressing
29 judgement to clients about their decisions to pursue abortion or contraception, offering
30 ultrasound services for purpose of using fetal images to dissuade women from abortion, and
31 providing false information on the links between abortion and adverse mental health sequelae,
32 breast cancer, and future infertility^{16, 17}; and
33

34 Whereas, Pregnancy Counseling Centers do not charge for services and are often not licensed
35 medical practices, therefore they are not held to the same state consumer protection statutes
36 and consumer protection regulations that medical practices must abide by⁹; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-420.954, "Truth and
2 Transparency in Pregnancy Counseling Centers," by insertion and deletion to read as follows, to
3 further strengthen our AMA policy against the dissemination of purposely incomplete or
4 deceptive information intended to mislead patients and the utilization of state and federal funds
5 for potentially biased services provided by Pregnancy Counseling Centers:
6

7 **Truth and Transparency in Pregnancy Counseling Centers H-420.954**

8 1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services
9 disclose information on site, in its advertising; and before any services are provided
10 concerning medical services, contraception, termination of pregnancy or referral for such
11 services, adoption options or referral for such services that it does and does not provide,
12 as well as fully disclose any financial, political, or religious associations which such
13 entities may have;
14

15 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical,
16 emotional, or financial means) by any agency offering crisis pregnancy services that aim
17 to discourage or interfere with a pregnant woman's pursuit of any medical services for
18 the care of her unplanned pregnancy;
19

20 3. Our AMA advocates that any entity providing medical or health services to pregnant
21 women that markets medical or any clinical services abide by licensing requirements
22 and have the appropriate qualified licensed personnel to do so and abide by federal
23 health information privacy laws, and additionally disclose their level of compliance to
24 such requirements and laws to patients receiving services;
25

26 4. Our AMA opposes the utilization of state and federal funding to finance such entities
27 offering crisis pregnancy services, which do not provide statistically validated evidence-
28 based medical information and care to pregnant women. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We feel that this resolution addresses important gaps in AMA policy surrounding crisis pregnancy centers, which can act as a public health threat to pregnant individuals nationwide by disseminating misleading medical information and violating reproductive rights. These centers endanger the health of pregnant women nationwide, who have a right to know the political and religious associations of the institutions from which they are receiving counseling services.

There are numerous policies set significant precedent such as, H-5.993 which affirms that early termination of pregnancy is a medical matter between the patient and physician thus there should be no external factors interfering. Our AMA supports the disclosure of information regarding services provided from any entity offering crisis pregnancy services. Further, it advocates that entities providing medical or health services abide by licensing requirements. However, given the current state of many pregnancy counseling centers and their deceitful tactics, a stronger rewording of current AMA policy is justifiable. Current AMA policy does not require crisis pregnancy centers to disclose their financial, political, or religious associations, leaving a gap for dubious practices to flourish. Further, these practices have been found to dissuade or sometimes coerce women seeking abortions by taking the image of a doctor (white coat) to steer a woman's choice away from abortion on a non-medical basis. The trust by our patients is us as physicians of the upmost importance and our image is part of this trust.

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RELEVANT AMA POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954

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

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

Res. 7, I-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(JUN-21)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, The World Health Organization has unequivocally defined infertility as a disease state and cause of disability¹; and

Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for transgender men, which can suppress ovulation, and estrogen therapy for transgender women, which can lead to impaired spermatogenesis and testicular atrophy^{2,3}; and

Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and oophorectomy, which results in permanent sterility^{2,3}; and

Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of respondents had received GAHT and 25% had undergone some form of GAS⁴; and

Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Society for Reproductive Medicine (ASRM) all recommend that transgender individuals receive counseling regarding potential loss of fertility and future reproductive options before initiating GAHT or undergoing GAS⁵⁻⁷; and

Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care Act created protections barring insurance discrimination based on sexual orientation and gender identity, although the current Administration has declined to defend this regulation and has been deferential to states⁸⁻¹⁰; and

Whereas, Employers and states that have implemented coverage of transition-related services have demonstrated minimal or no costs with vast immaterial/societal benefits^{10,11}; and

Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of economic benefit, it is still difficult for transgender patients to obtain insurance coverage for gender-affirming care, fertility counseling, and gamete preservation^{3,4,12}; and

Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with specific requirements determined on a state-by-state basis^{12,13}; and

Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around qualifying diagnoses is variable between states^{12,13}; and

Whereas, “Iatrogenic infertility” has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes¹²; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient’s physician (H-185.950)^{7,14}; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is “caused directly or indirectly by necessary medical treatments as determined by a licensed physician” (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.990 by addition as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950 by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Gender-affirming therapy, including hormone therapy and surgery, is important to improving the mental health of patients experiencing gender dysphoria. It is therefore a necessary medical treatment and any resulting complications should be considered iatrogenic. Our AMA supports payment for iatrogenic infertility. However, patients who undergo gender affirming therapy and have the complication of iatrogenic infertility are often denied coverage for fertility therapy. Our delegation believes this resolution is a critical step to correcting this problem.

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RELEVANT AMA POLICY**Right for Gamete Preservation Therapies H-65.956**

It is the policy of the AMA that (1): Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and (2) Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Res. 005, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all

payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Res. 150, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CMS Rep. 4, A-08 Appended: Res. 114, A-13 Modified: Res. 809, I-14

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122 A-08; Modified: Res. 05, A-16

Infertility Benefits for Veterans H-510.984

The AMA (1) Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; (2) Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; (3) Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; (4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

CMS Rep. 01, I-16; Appended: Res. 513, A-19

Storage & Use of Human Embryos- Ethics 4.2.5

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:

(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.

- (b) Made available to other patients for purposes of reproduction.
- (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
- (d) Allowed to thaw and deteriorate.
- (e) Otherwise disposed of.

Under no circumstances should physicians participate in the sale of stored embryos.

AMA Principles of Medical Ethics: I, III, IV, V

Issued: 2016

Assisted Reproductive Technology- Ethics 4.2.1

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. "Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

AMA Principles of Medical Ethics: I, V, VII

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Reference Committee A

1 Whereas, Americans entering the workforce currently have from one quarter to one eighth of the
2 average job tenure as workers now aging into retirement¹; and
3

4 Whereas, Trends such as a higher average worker education level and an increasing share of
5 available jobs in industries with shorter-tenured careers are also contributing to increasing
6 worker mobility, likely more so than any generational differences¹; and
7

8 Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40
9 years, decreasing the collective bargaining power of today's workers to attain benefits such as
10 quality health insurance²; and
11

12 Whereas, The number of Americans that have employer-sponsored health insurance has
13 declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among
14 low- and middle-income families³; and
15

16 Whereas, Even among those workers with employer-sponsored health insurance, as many as
17 25% have out-of-pocket costs so high as to be effectively uninsured⁴; and
18

19 Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on
20 employer-sponsored health insurance results in undesirable effects on the American worker
21 such as "job-lock" (being unable to leave a job because of reliance on its health benefits),
22 medical bankruptcy when a patient changes or loses their job while they or a family member
23 requires ongoing medical treatment, and downward pressure on wages⁵; and
24

25 Whereas, The predominance of employer-sponsored insurance arose by accident out of an
26 attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of
27 1942, and was never intended to become the principal form of health insurance in the United
28 States⁶; and
29

30 Whereas, As a result of these and other trends, reliance upon a health insurance system tied to
31 employment is becoming increasingly untenable for large portions of the United States
32 population; therefore be it
33

34 RESOLVED, That our American Medical Association recognize the importance of providing
35 avenues for affordable health insurance coverage and health care access to patients who do
36 not have employer-sponsored health insurance, or for whom employer-sponsored health
37 insurance does not meet their needs (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are
 2 unable to meet their health insurance or health care access needs through employer-sponsored
 3 health insurance, and that these patients must be considered in the course of ongoing efforts to
 4 reform the healthcare system in pursuit of universal health insurance coverage and health care
 5 access. (New HOD Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This policy position would create discussion around an important weakness in our country that all patients with employer-sponsored healthcare encounter. As we face discussions with the new administration around the future of healthcare, the AMA needs to have a clear answer to whether tying insurance to employment is a requirement for our support as an organization. There is no better way for the AMA to know how to move forward in this advocacy space than to know what our members think by bringing this to the floor of the HOD before a national political fight around healthcare which many members of the Biden administration and congress incorporated into their platforms.

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RELEVANT AMA POLICY

The Future of Employer-Sponsored Insurance H-165.829

Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges

Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843

Our AMA encourages employers to:

- a) promote greater individual choice and ownership of plans;
- b) enhance employee education regarding how to choose health plans that meet their needs;
- c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
- d) support increased fairness and uniformity in the health insurance market; and
- e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.

Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee A

Whereas, In 2016, the World Health Organization provisionally classified breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma¹; and

Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that this cancer is a lymphoma; and

Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical excision."²; and

Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance companies to cover surgery to remove the cancer and their breast implants, as the insurance company may initially classify the surgery as cosmetic and not cover it;³ therefore be it

RESOLVED, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This policy will help bring the spotlight on a disease often overlooked by insurance companies making it harder for this population of patients to cover the costs of their care.

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RELEVANT AMA POLICY **Breast Implants H-525.984**

Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91Modified: Sunset Report, I-01Reaffirmed: Res. 727, I-02Modified: CSAPH Rep. 1, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(JUN-21)

Introduced by: Illinois

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right¹; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access²; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than \$25,000 of annual income having access to internet as opposed to 93.5% of households with over \$50,000 of annual income^{3,4}; and

Whereas, One in three families who earn less than \$50,000 annually do not have high-speed home internet⁵; and

II. Broadband as a social determinant of health

Whereas, The United States Congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications⁶; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream^{7,8}; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors such as data allowances or pricing may affect consumers' use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area."⁷; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health⁹; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health¹⁰⁻¹³; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being¹⁴; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic^{12,13,15,16}; and

Whereas, Our AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that “optimizing the social determinants of health is an ethical obligation of a civil society”; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access¹⁷; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; $P=0.01$), were less likely to be black (24% versus 34%; $P<0.01$), and had higher median household income (21% versus 32% with income $< \$50,000$, 54% versus 49% with income of $\$50,000$ – $\$100,000$, 24% versus 19% with income $\geq \$100,000$)¹⁸; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country¹⁹; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care^{20,21}; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources^{14,20}; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning⁵; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic^{20,22}; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones²²; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic²³; and

V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic²⁴; and

Whereas, The FCC Lifeline program provides a choice between either discounted mobile internet access or discounted broadband access for qualifying low-income recipients²⁵; and

Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile broadband services are full substitutes in all cases⁷; and

Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for approximately 15 of the estimated 21.3 million people that lack home internet access^{26,27}; and

Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized program for which there is a significant backlog in applications and delay in application approvals, as well as a lack of an automatic application or automatic appeal process²⁵; and

Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still only allows 1 stream of 25mbps per household, limiting access for households with more than one person working/attending school from home²⁸; and

Whereas, In the 2020 legislative session as of October 2020, 43 states have considered legislation on broadband access²⁹; and

Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered government subsidized free broadband service for COVID impacted people^{30,31}; and

Whereas, It is probable that a stimulus package be proposed in the near future, which will likely include internet access as part of this package, between 2020 elections and the next meeting of the AMA House of Delegates^{32,33}; and

Whereas, AMA policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities sets precedent for the AMA advocating for internet access, and acknowledges the health benefit of internet access, but only asks for expansion of internet infrastructure in rural/underserved communities to provide "connectivity" rather than pushing for universal access to internet for those with significant limitations in access or financial constraints; and

Whereas, Universal coverage of home internet access would increase accessibility to this tool that is critical for patient health and public well-being; therefore be it

RESOLVED, That our American Medical Association recognize that internet access is a social determinant of health (New HOD Policy); and be it further

RESOLVED, That our AMA support universal access to broadband home internet (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to
 2 broadband internet, including federal, state, and local funding of broadband internet to reduce
 3 price, the establishment of automatic applications for recipients of Medicaid or other assistance
 4 programs, and increasing the number of devices and streams covered per household. (Directive
 5 to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This is an urgent issue.

The COVID-19 pandemic created a fast and unexpected growth in telemedicine. This surge in use demonstrates that virtual visits expand access to care, especially for underserved patient populations. However, it is apparent that there can also be digital disparity when patients do not have access to consistent and accessible internet access. If our health care delivery system continues to rely on digital platforms we must ensure that our patients using these tools have the necessary access to universal and consistent internet availability.

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Citation: Res. 208, I-18

Health, In All Its Dimensions, Is a Basic Right H-65.960

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

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

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and

establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08;

Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep.

17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT

Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res.

721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended:

BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208,

A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16;

Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17;

Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(JUN-21)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee A

1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow
2 networks; and
3

4 Whereas, These narrow networks often require patients to only see physicians within the county
5 in which the plan was purchased; and
6

7 Whereas, Patients are required to purchase a plan based on the county in which they reside;
8 and
9

10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of
11 choice making their comprehensive plan more of an expensive catastrophic plan; and
12

13 Whereas, This limits patient choice by preventing patients from choosing their plan based on
14 access to their physician of choice; therefore be it
15

16 RESOLVED, That our American Medical Association advocate for patients to have expanded
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip
18 code of their primary residence or where their physician practices, including the interstate
19 portability of plans. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The current Healthcare Marketplace plans often have very narrow networks affecting most physicians and their patients by limiting their patients' ability to choose a plan that includes their preferred physician. With patients currently required to purchase a plan based on the county in which they reside, this can result in the patients being unable to see their physician of choice if that physician does not practice in that county even if that physician practices in close proximity to the patient's residence. Ensuring that patients can utilize the physician of their choice is important in maintaining healthy patients who receive the right care at the right time. The AMA has no current policy regarding the expansion of plans that patients can choose from in the marketplace and the AMA is in the best position to advocate for these changes, especially for the many states that currently utilize the federally-run marketplaces. The public health is greatly improved where patients are able to access the physicians they are most comfortable with and this can also improve public health measures such as vaccination rates by improving patient confidence in the care they receive. Finally, with open enrollment typically occurring in late fall, any delay in adopting this policy would delay any possibility of implementing these changes to the marketplace until at least 2022, if not later.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(JUN-21)

Introduced by: Senior Physicians Section

Subject: Towards Prevention of Hearing-Loss Associated Cognitive Impairment

Referred to: Reference Committee A

1 Whereas, Our AMA holds out as a primary objective “to promote the art and science of medicine
2 and the betterment of public health;” and
3

4 Whereas, Our AMA has adopted policy in support of health promotion and preventive care,
5 community preventive services, healthy lifestyles, coverage for preventive care and
6 immunizations, health information and education, training in the principles of population-based
7 medicine, values-based decision-making in the healthcare system, and encouragement of new
8 advances in science and medicine via strong financial and policy support for all aspects of
9 biomedical science and research;¹⁻⁸ and
10

11 Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation⁹ as
12 well as for dementia treatment;¹⁰ and
13

14 Whereas, There is mounting evidence that there is a strong link between hearing impairment in
15 middle and later life and the development of cognitive, as well as social impairments and falls,
16 although its specific causality in relation to later cognitive loss has not yet conclusively been
17 established;¹¹⁻³¹ and
18

19 Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of
20 2017, amplified by the 2020 follow-up report¹³⁻¹⁵ concluded that age-related hearing loss (ARHL)
21 may account for nine percent of all cases of dementia, making this the single largest potentially
22 modifiable risk factor for that condition, beginning in mid-life; and
23

24 Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate,
25 and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold
26 increased risk of incident all-cause dementia over 10 years of follow-up in one study;²⁹ and
27

28 Whereas, Based on prior and pilot studies,³⁰⁻³¹ the causative link between hearing impairment in
29 middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE³²
30 and other clinical trials now in progress; and
31

32 Whereas, The return on investment for hearing remediation, especially but not exclusively in
33 mid-life, will be substantial and time-sensitive insofar as it may ameliorate (by delay in onset or
34 even prevention of cognitive decline) far more costly care for those with cognitive decline (direct
35 and indirect costs). Delaying the onset of Alzheimer’s Disease by even one year has significant
36 fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer’s disease
37 would save \$113 Billion by 2030. This underscores the urgency of current action to reduce the
38 cost of healthcare (including, and perhaps especially, to Medicare) while improving other
39 measures influencing the quality of life;³³⁻⁴⁰ and

Whereas, A generally held calculation for the yearly cost of caring for those with dementia exceeds \$307 billion as of 2010, and is expected to rise to \$624 billion in 2030 and \$1.5 trillion by 2050. The current yearly market cost of hearing aids in the US is estimated at \$9 billion. This suggests that, with a 9% increase in risk of development of cognitive loss later in life due to unaddressed hearing loss,^{13,15} remediating even this single important element linked to cognitive decline would be cost-effective immediately, and will be increasingly so in the future;^{39, 40} and

Whereas, The issue of hearing impairment is also a matter of health and social equity, with serious immediate and long-term consequences resulting from neglect of remediation. Unaddressed hearing loss reduces earnings potential and increases disability during gainful years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of hearing amplification and other forms of remediation is significant enough (even with over-the-counter products, which while possibly helpful do not come with professional guidance) to defer purchase and implementation by an indigent population;⁴⁶ and

Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention, as well as timely treatment of cognitive impairment and dementia is highly desirable for public health, for humane as well as financial reasons; and

Whereas, Congress has shown initial interest in expanding coverage for hearing remediation in the most recent bill HR 4618, "Medicare Hearing Act of 2019." The relation of hearing loss to cognitive loss was acknowledged, and the bill passed out of Committee with a favorable recommendation. The bill ultimately failed, but is likely to be refiled in the current Congressional session, affording a strategic opportunity for our AMA to more effectively advocate now for expanding coverage to include coverage of preventive strategies in middle age, promoting that as a way to mitigate future Medicare costs;⁴¹⁻⁴³ and

Whereas, Some developed countries such as Brazil have launched national efforts to bring hearing remediation to the masses⁴⁵ as a means of reducing later cognitive decline, suggesting that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and

Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing remediation are complex, and require physicians to be current, informed, and involved in the discussion with patients;^{44,47-48} and

Whereas, a number of groups have a stake in promoting hearing remediation, including professional and citizen organizations and Federal Agencies, such as the Agency for Health Research and Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD); therefore be it

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate for increasing hearing screening and avenues for
2 coverage for effective hearing loss remediation beginning in mid-life or whenever detected,
3 including third party insurance coverage, especially when such loss is shown conclusively to
4 contribute significantly to the development of, or to magnify the functional deficits of cognitive
5 impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take
6 Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Unaddressed hearing loss has a major effect on many physicians and patients, especially seniors. Additionally, unaddressed hearing loss has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, an important health care disparity issue for our AMA. Increased hearing screening and remediation is a public health issue that is very consistent with our mission and strategic plan. It is reliably estimated that at 9%, unaddressed age related hearing loss is the single most remediable cause of cognitive decline. Delaying the onset of cognitive decline by even one year has predictably VERY significant societal and fiscal benefits, and thus there is a remarkably negative societal impact for every year that this issue is not effectively addressed.

AMA has significant related policy, but important gaps exist, including education about the connection between hearing loss and cognitive decline, emphasizing the importance of hearing screening at MIDlife, in order to promote remediation, and thereby help to prevent cognitive decline. A few commercial insurers have begun to acknowledge the need. Our AMA must update policy and promote this trend. The proposed action is likely to have meaningful impact but requires new policy or modification of existing policy to implement. There is pending Congressional action that makes this a timely political issue. An AMA resolution is one of the most appropriate avenues to address the issue.

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5. H-425.972 Healthy Lifestyles
6. D-425.996 Implementing the Guidelines to Community Preventive Services
7. H-460.943 Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation
8. H-450.938 Value-Based Decision-Making in the Health Care System
9. H-185.929 Hearing Aid Coverage
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(JUN-21)

Introduced by: Young Physicians Section

Subject: Fertility Preservation Benefits for Active-Duty Military Personnel

Referred to: Reference Committee A

1 Whereas, According to Pentagon figures, over 200,000 women are in the active-duty U.S.
2 military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in
3 the Marine Corps in 2011;¹ and
4

5 Whereas, According to the U.S. Department of Veterans Affairs (VA), there were over 2 million
6 women veterans as of September 2015;² and
7

8 Whereas, According to the 2012 Committee Opinion on “Health care for women in the military
9 and women Veterans” from the American College of Obstetricians and Gynecologists (ACOG),
10 “military service is associated with unique risks to women’s reproductive health
11 Obstetrician—gynecologists should be aware of high prevalence problems (e.g., posttraumatic
12 stress disorder, intimate partner violence, and military sexual trauma) that can threaten the
13 health and well-being of these women;”³ and
14

15 Whereas, Both men and women in our U.S. military can suffer from infertility, sometimes directly
16 as a result of blast traumas and spinal cord injuries;⁴ and
17

18 Whereas, The U.S. Department of Defense (DOD) currently covers the cost of in vitro
19 fertilization (IVF) and infertility services for certain injured active duty personnel;⁵ and
20

21 Whereas, Under current Tricare policy, active-duty military personnel and their dependents have
22 some limited coverage for infertility care and oocyte cryopreservation services at six specific
23 military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD;
24 Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical
25 Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army
26 Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH;
27 and Madigan Army Medical Center in Seattle-Tacoma WA;^{6, 7} and
28

29 Whereas, This critical medical service is not fully available to active duty members of the military
30 and those working with the DOD; and
31

32 Whereas, AMA Policy H-150.984 (3)(4) “Infertility Benefits for Veterans” states that:
33 3)“Our AMA encourages the Department of Defense (DOD) to offer service members fertility
34 counseling and information on relevant health care benefits through TRICARE and the VA at
35 pre-deployment and during the medical discharge process. 4) Our AMA supports efforts by the
36 DOD and VA to offer service members comprehensive health care services to preserve their
37 ability to conceive a child and provide treatment within the standard of care to address infertility
38 due to service-related injuries”;⁶ and

Whereas, Fertility preservation for medical indications (such as prior to cancer treatment, organ transplants, or treatment for rheumatologic diseases) are covered under the VA but not covered by the DOD; and

Whereas, AMA Policy H-185.990 "Infertility and Fertility Preservation Coverage," states that: "Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician;"⁷ and

Whereas, AMA Policy H-185.922 "Right for Gamete Preservation Therapies" states that: "Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility;"⁸ therefore be it

RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2022 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for the AMA to work with relevant specialty societies to ensure TRICARE coverage for fertility preservation. We feel this resolution is important, especially as our brave service members deserve the best of care. However, this impacts a small number of patients and could potentially be addressed by specialty societies. The AMA also has policy on fertility preservation insurance coverage, so could potentially tackle this in DC without this specific resolution if an opportunity presented. While the current Congress is likely more receptive to reproductive health than the ones in the prior administration, we do not feel this is an urgent issue. Therefore, we feel this is a low priority resolution.

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9. AMA policy H-425.967 on "Disclosure of Risk to Fertility with Gonadotoxic Treatment"

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.

Citation: Res. 512, A-19

Right for Gamete Preservation Therapies H-185.922

Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.

Citation: Res. 005, A-19

Right for Gamete Preservation Therapies H-65.956

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

Veterans Administration Health System H-510.991

Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.

Citation: CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19

Health Care for Veterans and Their Families D-510.994

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990

Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).

Citation: (Sub. Res. 115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

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

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

Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18; Modified: Res. 305, I-19

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care

within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988

Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.

Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right¹; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access²; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than \$25,000 of annual income having access to internet as opposed to 93.5% of households with over \$50,000 of annual income^{3,4}; and

Whereas, One in three families who earn less than \$50,000 annually do not have high-speed home internet⁵; and

II. Broadband as a social determinant of health

Whereas, The United States congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications⁶; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream^{7,8}; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors such as data allowances or pricing may affect consumers' use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area."⁷; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health⁹; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health¹⁰⁻¹³; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being¹⁴; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic^{12,13,15,16}; and

Whereas, The AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that “optimizing the social determinants of health is an ethical obligation of a civil society”; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access¹⁷; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; $P=0.01$), were less likely to be black (24% versus 34%; $P<0.01$), and had higher median household income (21% versus 32% with income $<\$50,000$, 54% versus 49% with income of $\$50,000$ – $\$100,000$, 24% versus 19% with income $\geq \$100,000$)¹⁸; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country¹⁹; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care^{20,21}; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources^{14,20}; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning⁵; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic^{20,22}; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones²²; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic²³; and

V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic²⁴; and

1 Whereas, The FCC Lifeline program provides a choice between either discounted mobile
2 internet access or discounted broadband access for qualifying low-income recipients²⁵; and
3

4 Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile
5 broadband services are full substitutes in all cases⁷; and
6

7 Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for
8 approximately 15 of the estimated 21.3 million people that lack home internet access ^{26,27}; and
9

10 Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized
11 program for which there is a significant backlog in applications and delay in application
12 approvals, as well as a lack of an automatic application or automatic appeal process²⁵; and
13

14 Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still
15 only allows 1 stream of 25mbps per household, limiting access for households with more than
16 one person working/attending school from home²⁸; and
17

18 Whereas, In the 2020 legislative session as of October 2020, 43 states have considered
19 legislation on broadband access²⁹; and
20

21 Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in
22 light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered
23 government subsidized free broadband service for COVID impacted people^{30,31}; and
24

25 Whereas, It is probable that a stimulus package be proposed in the near future, which will likely
26 include internet access as part of this package, between 2020 elections and the next meeting of
27 the AMA House of Delegates^{32,33}; and
28

29 Whereas, AMA policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health
30 Disparities," sets precedent for the AMA advocating for internet access, and acknowledges the
31 health benefit of internet access, but only asks for expansion of internet infrastructure in
32 rural/underserved communities to provide "connectivity" rather than pushing for universal
33 access to internet for those with significant limitations in access or financial constraints; and
34

35 Whereas, Universal coverage of home internet access would increase accessibility to this tool
36 that is critical for patient health; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-478.980, "Increasing
2 Access to Broadband Internet to Reduce Health Disparities," by addition and deletion to read as
3 follows:

4
5 INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH
6 DISPARITIES, H-478.980

7 1. Our AMA recognizes internet access as a social determinant of health and will
8 advocate for universal and affordable access to the expansion of broadband and
9 high-speed and wireless internet and voice connectivity, especially in to all rural
10 and underserved areas of the United States while at all times taking care to
11 protecting existing federally licensed radio services from harmful interference that
12 can be caused by broadband and wireless services.

13 2. Our AMA will advocate for federal, state, and local policies to support
14 infrastructure that reduces the cost of broadband and wireless connectivity and
15 covers multiple devices and streams per household. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses the issue of internet access within healthcare and education, especially given the context of the COVID-19 pandemic. Our delegation considers this resolution a priority given our nation's increased usage of internet and need to mitigate rising disparities. The resolution highlights how much of day-to-day healthcare and education access has shifted to an online format. While the United States internet usage has increased 34% between January and April 2020 during the COVID-19 pandemic among families with access to broadband, one in five households with school-age children (ages 6-18) still do not have personal broadband internet access at home during the COVID-19 pandemic.

Moreover, the current administration is considering a \$100B proposal for broadband infrastructure. This resolution provides our AMA the opportunity to highlight and support legislation to reduce barriers and increase access to broadband internet to reduce healthcare inequities.

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Res. 208, I-18

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19

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 is an issue of highest priority for the American Medical Association.

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

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

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

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

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

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

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03;

Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this

technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation, A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation, A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation, I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(JUN-21)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

1 Whereas, School based health centers (SBHCs) are facilities located within the academic
2 setting, primarily for those in kindergarten through 12th grade, that provide an array of high
3 quality health care services to students, ranging from primary medical care to dental, vision, and
4 behavioral health services¹; and

5
6 Whereas, SBHCs were originally created to increase access to primary health care and
7 preventative health services, often for the most vulnerable underserved populations¹; and

8
9 Whereas, Due to their focus on preventative care and health maintenance, SBHCs are well
10 suited to address the negative consequences of health disparities in low income urban and rural
11 communities, such as depression, obesity, chronic metabolic issues, which are further
12 associated with poor academic performance²; and

13
14 Whereas, SBHCs are cost-effective because they increase access to preventive care and
15 reduce utilization of acute care services, leading to a net savings for Medicaid of \$30 to \$969
16 per visit³; and

17
18 Whereas, In a systematic review, SBHCs were also found to substantially reduce the number of
19 ED visits and hospital utilizations²; and

20
21 Whereas, SBHCs are considered a provider type in only seven states, making it difficult for
22 them to receive proper Medicaid reimbursements⁴; and

23
24 Whereas, As a result of difficulties in obtaining Medicaid reimbursements, many SBHCs must
25 rely on public funding to continue to provide important healthcare services⁵; and

26
27 Whereas, SBHCs are not differentiated on Medicaid claims data making it impossible to identify
28 what services were rendered by an SBHC versus a different type of provider and thus making it
29 difficult to track and attribute improvements in quality of care or outcomes to SBHCs; and

30
31 Whereas, Current AMA policy “supports the concept of ... SBHCs” (H-60.921) and recommends
32 minimum standards for school-based health services (H-60.991) but does not support the
33 expansion of these centers or methods to increase funding, therefore be it

1 RESOLVED, That our American Medical Association promote the implementation, use, and
 2 maintenance of school based health centers by amending H-60.921, "School-Based and
 3 School-Linked Health Centers," by addition and deletion to read as follows:

4
 5 **School-Based and School-Linked Health Centers, H-60.921**

6 1. Our AMA supports the concept of adequately equipped and staffed the
 7 implementation, maintenance, and equitable expansion of school-based or school-linked
 8 health centers (SBHCs) for the comprehensive management of conditions of childhood
 9 and adolescence.

10 2. Our AMA recognizes that school-based health centers increase access to care in
 11 underserved child and adolescent populations.

12 3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers
 13 for research and quality improvement purposes.

14 4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health
 15 centers at the state and federal level, including, but not limited to the recognition of
 16 school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA recognizes health care as a human right and strives to increase access through various methods. School-Based Health Centers (SBHCs) are an important tool for providing healthcare for kids in kindergarten through 12th grade, especially for underserved populations. However, it is difficult for SBHCs to bill Medicaid, leading to financial problems for these critical safety nets. Our AMA has previously supported the concept of SBHCs but not addressed their difficulty in obtaining funding. This resolution will amend current policy to support the expansion of these centers, enable future research on quality improvement methods, and enable SBHCs to receive reimbursement from Medicaid. These asks aligns with the AMA's new focus on equity in healthcare and we believe should be considered a priority for the House of Delegates.

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RELEVANT AMA POLICY

School-Based and School-Linked Health Centers H-60.921

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

Providing Medical Services through School-Based Health Programs H-60.991

1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(JUN-21)

Introduced by: Medical Student Section

Subject: Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration

Referred to: Reference Committee A

1 Whereas, There are over 2.2 million incarcerated people in the United States¹; and

2
3 Whereas, Incarceration is associated with increased rates of stress-related illness, obesity,
4 infection, and transmission of communicable diseases with resultant increases in mortality, even
5 after adjusting for socioeconomic factors, tobacco and alcohol use, and adverse life events²⁻⁷;
6 and

7
8 Whereas, The Social Security Act currently prohibits the use of federal services such as
9 Medicaid for inmates in jails and prisons unless treatment occurs at an outside institution for at
10 least 24hrs, thereby limiting access to healthcare for the duration of incarceration^{8,9}; and

11
12 Whereas, 65% of the 10.6 million people admitted to local jails in 2016 were presumed innocent
13 and awaiting trial, signifying that the suspension of federal benefits disproportionately impacts
14 those who cannot afford to post bail in spite of their presumed innocence and thereby
15 contributes to significant disruptions in care¹⁰⁻¹²; and

16
17 Whereas, Inmates and their families are charged a variety of fees to help offset correctional
18 costs, including booking, room and meals, hygiene supplies, phone calls, and medical care¹³⁻¹⁷;
19 and

20
21 Whereas, Both the Federal Bureau of Prisons and prisons in at least 35 states require a
22 copayment (copay) to access healthcare with the average co-pay across the 50 states being
23 \$3.47^{13,18}; and

24
25 Whereas, Prisoners receive an average minimum wage of only 14 cents per hour with at least 7
26 states offering no salary at all, thus requiring about 25 hours of work to afford the copayment for
27 medical care^{18,19}; and

28
29 Whereas, Co-payments that are difficult to afford can prevent prisoners from seeking necessary
30 treatment to the detriment of themselves and of the wider prison population in the case of
31 communicable diseases²⁰; and

32
33 Whereas, An analysis by Pew Charitable Trusts found that states collectively spent
34 approximately 7.7 billion dollars for inmate healthcare in 2011, and states reported that they
35 only recouped between \$190,000 and \$500,000 a year from prisoner co-pays, indicating co-
36 pays are not an effective means of offsetting correctional costs while remaining a barrier to
37 accessing care²⁰; and

1 Whereas, Permitting the use of federal services during incarceration could further reduce
2 coverage gaps, minimize the administrative burden associated with suspension/termination, and
3 improve health outcomes²¹⁻²⁴; and
4

5 Whereas, If federal services are made available during incarceration, jails and prisons
6 requesting federal reimbursement would be required to meet appropriate national standards for
7 minimum care pursuant to the Social Security Act^{21,25,26}; and
8

9 Whereas, Our AMA encourages adoption of national standards to help ensure quality, equitable
10 healthcare for all incarcerated patients (D-430.997); and
11

12 Whereas, During the COVID-19 pandemic, Illinois, South Carolina, and California submitted
13 Section 1115 waivers asking to waive the Medicaid inmate exclusion for COVID-19 testing and
14 treatment, with Illinois citing that public health benefits will exceed costs^{25,27-29}; and
15

16 Whereas, An interruption in insurance coverage also adds to the difficulty of post-release
17 transitions of care and is associated with poor chronic disease management, significant
18 infectious disease transmission, and increased mortality³⁰⁻³³; and
19

20 Whereas, An estimated 57% of individuals released from prison are either Medicaid-eligible or
21 eligible for federal tax credits under the Affordable Care Act, so disease complications and
22 transmission due to lapses in access to care during and immediately following incarceration
23 incur significant costs to the federal government^{34,35}; and
24

25 Whereas, Recently incarcerated individuals who are enrolled in Medicaid at time of release are
26 more likely to access and receive community services, have fewer repeat detentions, and
27 greater time between detentions^{36,37}; and
28

29 Whereas, Permitting the use of federal funding to match inmate health expenses would help
30 states maintain a balanced budget while adequately addressing inmate health needs, as
31 evidenced by estimated annual savings of up to \$4.7 billion if Medicaid expansion states are
32 able to cost-share their corrections budgets³⁸⁻⁴⁰; therefore be it
33

34 RESOLVED, That our American Medical Association advocate for the continuation of federal
35 funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health
36 Insurance Program, for otherwise eligible individuals in pre-trial detention (Directive to Take
37 Action); and be it further
38

39 RESOLVED, That our AMA advocate for the prohibition of the use of co-payments to access
40 healthcare services in correctional facilities (Directive to Take Action); and be it further

1 RESOLVED, That our AMA amend policy H-430.986 by addition to read as follows:

2
3 HEALTH CARE WHILE INCARCERATED, H-430.986

4 1. Our AMA advocates for adequate payment to health care providers, including
5 primary care and mental health, and addiction treatment professionals, to encourage
6 improved access to comprehensive physical and behavioral health care services to
7 juveniles and adults throughout the incarceration process from intake to re-entry into
8 the community.

9 2. Our AMA supports partnerships and information sharing between correctional
10 systems, community health systems and state insurance programs to provide access to
11 a continuum of health care services for juveniles and adults in the correctional system.

12 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid
13 applications from juveniles and adults who are incarcerated.

14 4. That our AMA encourage state Medicaid agencies to work with their local
15 departments of corrections, prisons, and jails to assist incarcerated juveniles and adults
16 who may not have been enrolled in Medicaid at the time of their incarceration to apply
17 and receive an eligibility determination for Medicaid.

18 5. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.

19 ~~56.~~ Our AMA encourages states not to suspend rather than terminate Medicaid
20 eligibility of juveniles and adults upon intake into the criminal justice system and
21 throughout the incarceration process, and to reinstate coverage when the individual
22 transitions back into the community.

23 ~~67.~~ Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS),
24 and state Medicaid agencies to provide Medicaid coverage for health care, care
25 coordination activities and linkages to care delivered to patients up to 30 days before
26 the anticipated release from adult and juvenile correctional facilities in order to help
27 establish coverage effective upon release, assist with transition to care in the
28 community, and help reduce recidivism.

29 ~~78.~~ Our AMA advocates for necessary programs and staff training to address the
30 distinctive health care needs of incarcerated women and adolescent females, including
31 gynecological care and obstetrics care for pregnant and postpartum women.

32 ~~89.~~ Our AMA will collaborate with state medical societies and federal regulators to
33 emphasize the importance of hygiene and health literacy information sessions for both
34 inmates and staff in correctional facilities.

35 ~~910.~~ Our AMA supports: (a) linkage of those incarcerated to community clinics upon
36 release in order to accelerate access to comprehensive health care, including mental
37 health and substance abuse disorder services, and improve health outcomes among
38 this vulnerable patient population, as well as adequate funding; and (b) the
39 collaboration of correctional health workers and community health care providers for
40 those transitioning from a correctional institution to the community. (Modify Current
41 HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks our AMA to advocate for people who have been incarcerated to continue to (1) receive federal health insurance benefits both prior to trial and throughout the duration of their incarceration and (2) minimize any co-payments made in prison. It highlights a gap in the coverage of incarcerated individuals and the subsequent impact on treatment of chronic conditions, public health of communities of color, and increased federal government spending as a result of this interruption in federal services.

The topic has its foundations in the AMA's commitment to protecting vulnerable populations, which objectively includes incarcerated persons. Disparities in access to care for vulnerable populations in prison facilities are clearly within the AMA's purview, and there is clearly a strong existing relationship between the AMA and the National Commission on Correctional Health Care which is opposed to copayments. As detailed in this resolution copayments in prison facilities do not appear to add economic value or improve quality in correctional facilities' provision of healthcare, and that the cost of administering these copayment programs is greater than the amount collected, thereby contributing to rather than reducing healthcare costs.

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

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

CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

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

Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee A

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

Whereas, Direct medical costs for diagnosed diabetes were estimated at \$327.2 billion in 2017, with nearly \$102 billion lost due to lower productivity resulting from diabetes³; and

Whereas, The annual average medical cost per person with diabetes is \$13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin⁴; and

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

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient's prescription drug coverage plan⁶; and

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

Whereas, Seven states have approved legislation on insulin copayment caps since April 2020, instituting a \$35-\$100 maximum copayment for a 30-day insulin supply⁸; and

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

Whereas, Individual and family savings resulting from caps on insulin copayments have the potential to alleviate financial burden¹⁰; and

Whereas, The AMA has policy consistent with the principle of increasing access to prescription medications including insulin for patients¹¹⁻¹⁶; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan¹⁷; therefore be it

RESOLVED, That our American Medical Association amend policy H-110.984, "Insulin Affordability," by addition and deletion to read as follows:

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Insulin cost and access is a very urgent issue for many of our patients, and we anticipate that this policy may spur state and local efforts to implement copay caps. This resolution asks the AMA to address the issue of rising monthly copayments of insured patients by amending existing policy titled "Insulin Affordability H-110.984." In advocacy, we have seen that drug pricing, particularly insulin prices, is a very active topic in legislation and policy reform. It would be relevant and timely for the AMA to speak on this issue.

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RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
 - a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
 - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - c. The use of any international drug price index or average should preserve patient access to necessary medications;
 - d. The use of any international drug price index or average should limit burdens on physician practices; and
 - e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984

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

CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987

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

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

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

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

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997

Our AMA:

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

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

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

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

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

Reducing Prescription Drug Prices D-110.993

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

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

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Res. 211, A-04; Reaffirmation: I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(JUN-21)

Introduced by: Medical Student Section

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

Referred to: Reference Committee A

Whereas, More than 33% of youth entering foster care have a chronic medical condition and up to 80% struggle with significant mental health conditions, requiring sophisticated long-term medical attention well past the age of 18 ^{1,2}; and

Whereas, Many youths in the foster care system struggle to receive regular health care as they frequently change caregivers and locations, often leading to gaps in their medical and immunization records and poor long term treatment follow through ¹; and

Whereas, Nearly 20,000 children age out of the foster system each year, with the majority leaving with inadequate educational, social and financial support amongst other necessities ^{3,4}; and

Whereas, Around 26,000 former foster youth face significant challenges in receiving health care each year ^{5,6}; and

Whereas, Children aged out of the foster system are at increased risk for a lifetime of health problems including severe obesity, diabetes, and stroke amongst others due to adverse childhood experiences⁷; and

Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who have aged out of the foster care system in their state until their 26th birthday ⁸; and

Whereas, Currently 37 states interpret the law to require Medicaid coverage for 18 to 26-year-old youths who aged out of the foster care system in their own state, not any other state ^{8,9}; and

Whereas, AMA policy supports comprehensive, evidence-based care only for children currently in foster care (H-60.910); therefore be it

RESOLVED, That our American Medical Association amend policy H-60.910, by addition and deletion to read as follows:

Addressing Healthcare Needs of ~~Youth Children~~ in Foster Care, H-60.910

1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ youth in foster care.

2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid of other publicly funded health coverage in their state until at least 26 years of age. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes health protections and access for vulnerable populations, including youth of the foster care system. This resolution turns AMA's attention to a large, at-risk population needing more consistent access to care, especially with the possibility of anticipated changes in healthcare policy approaches at the federal and state level. Current AMA policy is light on the subjects of transitions of care and foster youth; therefore, this resolution addresses an important policy gap and expands the reach of AMA's advocacy efforts.

While existing resolutions H-60.910 and H-185.929 are broadly inclusive of infants and children, they are not inclusive of aged-out foster care individuals.

This resolution reveals the lack of homogeneity in Medicaid policy: 37 of the 50 states limit coverage to those who have aged-out from the foster care system within their own state. Aged-out individuals across the nation can receive timely detection and treatment for chronic health illness and mental health problems, both of which are reported at higher rates than the general populace. Efforts by the AMA to increase care will also identify those who did not receive appropriate immunization since exiting the foster care system.

The new language will help ensure that all aged-out foster care individuals are supported until the age of 26, regardless of residence. Thus, we urge that our AMA consider this resolution and place this marginalized population on a trajectory towards a better quality of life with physical and mental wellbeing.

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4. Youth Who Relocate From Another State. FosterClub; 2018.
5. Wilson-Simmons R, Dworsky A, Tongue D, Hulbutta M. NCCP | Fostering Health: The Affordable Care Act, Medicaid, and Youth Transitioning from Foster Care; 2016.
6. Gorman A. Kaiser Health News. For Former Foster Kids, Moving Out Of State Can Mean Losing Medicaid; 2015.
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8. Ensuring Access to Medicaid Coverage for Former Foster Care Youth. Medicaid and CHIP; 2017.
9. Weiner J. Medicaid for Some Former Foster Youth...But Not All. University of Pennsylvania; 2014.

RELEVANT AMA POLICY**Addressing Healthcare Needs of Children in Foster Care H-60.910**

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Redefining the Definition of Harm

Referred to: Reference Committee B

1 Whereas, Respecting and maintaining patients' confidentiality is imperative for the health and
2 well-being of adolescent patients, the current HIPAA definitions only allow a physician to
3 withhold the release of information in cases of anticipated *physical* harm to the patient or
4 another individual; and

5
6 Whereas, The release of requested PHI on patients to their proxies and/or representatives in
7 sensitive areas like reproductive health, mental health or substance use may not result in
8 physical harm to the adolescent, it could result in severe mental anguish or emotional distress
9 as they deal with the reaction from their family members and breach of privacy by their provider;
10 and

11
12 Whereas, Pediatric patients, including adolescents, are unique in that their legal rights to
13 provide consent and receive confidential care are limited, pediatricians and other clinicians who
14 provide health care for children and adolescents, and who are stewards of EHI for those
15 patients, should be granted discretion and latitude in sharing EHI when they are concerned
16 about the impact/consequences for the child; and

17
18 Whereas, Adolescents by their nature often act impulsively, release of sensitive PHI that they do
19 not want shared with others could result in mental or emotional harm that could lead to physical
20 self-harm or an impulse to harm others; and

21
22 Whereas, Under current regulations (both HIPAA and the 21st Century Cures Act Interoperability
23 Final Rule) physicians must release health information even when, in their professional
24 judgement, they believe that doing so could emotionally or psychologically harm their patient;
25 therefore be it

26
27 RESOLVED, That our American Medical Association advocate to the Office of Civil Rights to
28 revise the definition of harm to include mental and emotional distress. Such a revision would
29 allow additional flexibility for clinicians under the Preventing Harm Exception, based on their
30 professional judgement, to withhold sensitive information they believe could cause physical,
31 mental or emotional harm to the patient (Directive to Take Action); and be it further

32
33 RESOLVED, That our AMA advocate that the Office of Civil Rights assemble a commission of
34 medical professionals to help the office review the definition of harm and provide scientific
35 evidence demonstrating that mental and emotional health is intertwined with physical health.
36 (Directive to Take Action)

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

Received: 05/07/21

AUTHORS STATEMENT OF PRIORITY

The Federal Office of the National Coordinator for Health Information Technology allows physicians to block the release of medical information to patients and families that is “likely to endanger the life or physical safety of the individual or other person”, it currently excludes psychological or emotional harm, this resolution asks that that those harms be added as reasons a physician can choose to withhold or delay the release of medical information. Reducing harm to patients and families is an AMA priority, and the recently enacted medical information release rules will cause harm if psychological or emotional issues are not included in the definition of harm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Studying Physician Supervision of Allied Health Professionals Outside of
Their Fields of Graduate Medical Education

Referred to: Reference Committee B

Whereas, Advanced practice providers and allied health professionals are required under the laws of many states to be supervised to some degree by a physician; and

Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/gynecologists supervising social workers in the provision of group therapy¹ and plastic surgeons supervising physician assistants who advertise themselves as “dermatologists”²; and

Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers practicing in various fields while being nominally supervised by physicians not trained in those fields; and

Whereas, Physicians without appropriate training supervising advanced practice providers outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients; therefore be it

RESOLVED, That our American Medical Association conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians’ completed residencies and fellowships. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$100,000.

Received: 05/10/21

AUTHOR’S STATEMENT OR PRIORITY

As allied health providers have gained temporary independence and increased credit for their work during the pandemic, a proactive AMA attention and adequate data regarding supervision is needed to ensure that the supervision we are advocating for is indeed being provided and being done so for the specialty and procedures the physician is qualified to perform and oversee. The results of this study will be able to better inform our advocacy efforts and identify areas where our advocacy is not aligning with the standards we are holding ourselves to and will identify if we need to better regulate ourselves.

References:

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2. Al-agba N. *The P.A. Problem: Who You See and What You Get*. The Healthcare Blog. 24 Nov 2017. <https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/>. Accessed 18 Sep 2019.

RELEVANT AMA POLICY

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.

Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964

1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.

2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.

Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Health Workforce H-200.994

The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965

The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.

Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15) The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

Protecting Physician Led Health Care H-35.966

Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment. Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17;

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978

The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(JUN-21)

Introduced by: Pennsylvania

Subject: Increasing Residency Positions for Primary Care

Referred to: Reference Committee B

Whereas, We have many physicians (known to be in the thousands within the United States) that have completed the intense and specific education required in medical school whether at allopathic or osteopathic institutions and have successfully passed USMLE part 1, 2 CK and 2 CS or comparable examinations, but have not been able to obtain a residency due to the shortage of residency positions in the United States; along with a known shortage of physicians within the United States currently and presumed well into the future due to our aging population; and

Whereas, Even with the known shortage of physicians, and the increasing number of physicians without residencies expands as more and more candidates go unmatched due to the cap on Medicare support for graduate medical education residency positions are not increasing adequately to support the physicians that are available nor correcting the need for more practicing physicians; therefore be it

RESOLVED, That our American Medical Association prioritize the number of accredited residency positions, with the goal to increase the overall number especially in specialties deemed primary care (Directive to Take Action); and be it further

RESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical education. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We view this to be a high priority rather than a top priority since it has a significant impact on a subset of physician, yet it has direct implication to physician shortage and thus effects patient care through altering scope of practice issues. Extended care providers champion manpower deficiencies in rural and economically challenged urban areas. This resolution that attempts to match the number of residencies with the number of certified candidates has benefits to patient care as a whole. Clearly as the resolution ask, we are requesting that the AMA continue to advocate for increased GME funding and to direct that funding particularly toward increases in what would be considered primary care residencies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(JUN-21)

Introduced by: Pennsylvania

Subject: Making State Health Care Cost Containment Datasets Free of Cost and
Readily Available for Academic Research

Referred to: Reference Committee B

Whereas, All-payer claims databases (APCDs) are centralized databases created to enable healthcare transparency and inform health policies at the state level; and

Whereas, APCDs are critical for emergent statewide research on topics including COVID-19; and

Whereas, APCDs often self-publishes high-level summaries of various aspects of the collected data in a format unsuitable for research; and

Whereas, APCDs deidentified dataset pricing structure is costly, curbing its use in academic research by students and scientists, thereby limiting utilization of this important data to assess novel questions; therefore be it

RESOLVED, That our American Medical Association advocate for affordable and open access to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

All-Payer Claims Databases, such as the PCH4 in Pennsylvania, allow for increased transparency of costs in the American healthcare system. Price transparency is a concept already supported by our AMA, but this resolution provides a specific example of existing raw datasets at the state level that are either inaccessible or too costly for effective utilization in academic research. We feel this is timely because, particularly in a time when health care may be experiencing a shift or even upheaval in the context of the current pandemic, academic researchers must have feasible access to the appropriate data to come to fair and effective conclusions regarding cost containment and proper use of healthcare resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(JUN-21)

Introduced by: Illinois

Subject: Ransomware and Electronic Health Records

Referred to: Reference Committee B

1 Whereas, Electronic health records are used as a repository of actionable medical records
2 which is used by healthcare providers to provide optimal care to patients; and
3

4 Whereas, Access to electronic records in a timely fashion at the point of care can provide
5 measurable and invaluable details about a patient's health history, including medications and
6 allergies, medical and surgical history, family and social history, any of which could be used in
7 treatment decisions which have measurable impact on the care provided and ultimately patient
8 outcomes; and
9

10 Whereas, Ransomware is a form of malware that encrypts a victim's files. The attacker then
11 demands a ransom from the victim to restore access to the data upon payment; and
12

13 Whereas, Ransomware can significantly interfere with the types and quality of care provided to
14 patients by physicians and other health care entities, even to the degree of putting a patient's
15 health and life at risk; therefore be it
16

17 RESOLVED, That our American Medical Association adopt policy acknowledging that
18 healthcare data interruptions are especially harmful due to potential physical harm to patients
19 and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and
20 any other malware on independent physicians and their practices, healthcare organizations, or
21 other medical entities involved in providing direct and indirect care to patients (New HOD
22 Policy); and be it further
23

24 RESOLVED, That our AMA seek to introduce federal legislation which provides for the
25 prosecution of perpetrators of ransomware and any other malware on any and all healthcare
26 entities, involved in direct and indirect patient care, to the fullest extent of the law. (Directive to
27 Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely and urgent.

Each and every day digital attacks occur in our health care delivery system. When a data breach occurs and system access is blocked it can be extremely harmful for patients.

Timely access to patient health care information and data is essential. Our current system for protecting patient EHR information from ransomware is not working. There need to be more severe penalties against perpetrators of malware and ransomware to deter future attacks and better protect patient information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(JUN-21)

Introduced by: Illinois

Subject: Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Referred to: Reference Committee B

1 Whereas, A topical stock-item medication is an unlabeled ointment or drop that the hospital
2 operating room (OR), or Emergency Room (ER), or Ambulatory Surgical Treatment Center
3 (ASTC) staff has on stand-by or is retrieved from a dispensing system for a specified patient for
4 use during a procedure or visit; and
5

6 Whereas, Topical stock-item agents are charged to the patient, but unused medication often
7 gets discarded when the patient is discharged, even if the medication is recommended for post-
8 discharge care to aid in the patient's healing; and
9

10 Whereas, Because regulations governing the ability to dispense the remaining portion of stock-
11 item medications for post-discharge use can be unclear or appear overly burdensome, many
12 facilities do not allow the practice; and
13

14 Whereas, Patients may need to purchase duplicate agents for post-discharge use, increasing
15 patient cost and creating medication waste; and
16

17 Whereas, Similar issues of cost inefficiencies and medical waste arise with the use of
18 medications such as multiuse eye drops that are only allowed for single-patient use, but could
19 safely be used in multiple patients; and
20

21 Whereas, The Joint Commission has previously approved specific policies and procedures
22 implemented by the Utah Valley Regional Medical Center for the use of multi dose eye drops in
23 multiple patients; therefore be it
24

25 RESOLVED, That our American Medical Association work with national specialty societies,
26 state medical societies and/or other interested parties to advocate for legislative and regulatory
27 language that permits the practice of dispensing stock-item medications to individual patients
28 upon discharge in accordance with labeling and dispensing protocols that help ensure patient
29 safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take
30 Action); and be it further
31

32 RESOLVED, That our AMA work with the Food and Drug Administration, national specialty
33 societies, state medical societies and/or other interested parties to advocate for legislative and
34 regulatory language that permits the practice of using multi dose eye drop bottles pre-
35 operatively in accordance with safe handling and dispensing protocols that help ensure patient
36 safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take
37 Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is urgent. Health care costs have been rising at an unsustainable rate for years, jeopardizing patient access to care as costs escalate across all levels of the health care system. There is significant medical waste associated with the disposal of certain stock medications, which patients could continue to use safely if they were dispensed to the patient upon discharge. We should quickly pursue clarifying legislative and regulatory language that removes this barrier to the efficient and safe use of medications that would otherwise be wasted.

Reference:

Using multi dose eye drops in a health care setting: a policy and procedural approach to safe and effective treatment of patients.
Jensen MK, et al. JAMA Ophthalmology 2014. <https://jamanetwork.com/journals/jamaophthalmology/article-abstract/1901216>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(JUN-21)

Introduced by: American Academy of Dermatology, College of American Pathologists,
Missouri, Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho,
Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming,
Pennsylvania, Society for Investigative Dermatology, South Carolina, Iowa,
American Society for Dermatologic Surgery

Subject: ONC's Information Blocking Regulations

Referred to: Reference Committee B

1 Whereas, On May 1, 2020, the Office of the National Coordinator for Health Information
2 Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) published their
3 separate but interrelated final rules implementing provisions of the 21st Century Cures Act
4 (Cures) regarding interoperability, patient access to health data, data transparency electronic
5 health information blocking and the ONC Health IT Certification; and
6

7 Whereas, These twin regulations aim to advance greater and widespread sharing of health
8 information and transparency across the health care spectrum as well as promising to reduce
9 administration burdens; and
10

11 Whereas, Both final rules are extensive and highly complex, impacting software technology
12 developers, health information technology (HIT) vendors, payors, hospitals, medical practices,
13 physicians, and certain provisions raise compliance concerns for physicians with respect to
14 sharing, intervening and/or blocking patient's clinical information; and
15

16 Whereas, The ONC defines information blocking as "...a practice by a health IT developer of
17 certified health IT, health information network, health information exchange, or health care
18 provider that, except as required by law or specified by the Secretary of Health and Human
19 Services (HHS) as a reasonable and necessary activity, is likely to interfere with access,
20 exchange, or use of electronic health information (EHI);" and
21

22 Whereas, The ONC has established eight exceptions delineating activities that do not constitute
23 information blocking, provided that certain conditions are met; and
24

25 Whereas, These ONC exceptions are intended to support and sustain "seamless and secure
26 access, exchange, and use of electronic health information (EHI) and offer actors—health care
27 providers, health IT developers, health information exchanges (HIEs) or networks (HINs)—
28 certainty that practices that meet the conditions of an exception will not be considered
29 information blocking;" and
30

31 Whereas, The ONC has classified eight exceptions in two categories—either involving not
32 fulfilling requests to access, exchange, or use EHI or involving procedures for fulfilling requests
33 to access, exchange, or use EHI; and
34

35 Whereas, The "Preventing Harm Exception" requires that physicians share a wide variety of
36 medical information—including clinical progress notes, prescription medications and lab test

1 results—when readily available, in timely fashion and without delay, unless an exception to
2 delay or withhold the release of the patient’s information applies; and
3

4 Whereas, This requirement for immediate, automatic or “without delay” release of lab results to
5 patients with or without the knowledge of the ordering physician strains and undermines the
6 integrity of the physician-patients relationship and creates clinical workflow burdens and
7 compliance challenges for certain medical specialties that rely on surgical pathology lab testing,
8 results and inter-physician consultation with their pathologists; and
9

10 Whereas, Actors, including physicians, are afforded certain technical, compliance flexibilities
11 under the information blocking provisions and its concomitant exceptions based on necessity,
12 reasonableness, good faith efforts and professional clinical judgement within the scope and
13 context of treating patients and preventing harm; and
14

15 Whereas, The ONC delayed the original compliance date for its information blocking provisions
16 from November 2, 2020, to April 5, 2021, despite the AMA and other stakeholders urging a
17 delay beyond the April 5, 2021 deadline; and
18

19 Whereas, Both deadlines still fall within the current COVID-19 public health emergency (PHE)
20 that has caused uncertainties and challenges for the health care sector in general, with small
21 and medium-sized medical practices facing ongoing, acute economic hardship; and
22

23 Whereas, § 4004 of the Cures Act authorizes and grants regulatory discretion to the Secretary
24 of the Department of Health and Human Services (HHS) to identify reasonable and necessary
25 activities that do not constitute information blocking; therefore be it
26

27 RESOLVED, That our American Medical Association advocate for additional time and
28 compliance leeway for physicians by urging the Office of the National Coordinator for Health
29 Information Technology (ONC) to broaden and relax their current regulatory requirements based
30 on the following critical enumerated requests:

- 31 a. Urge the ONC to strike the right balance between the demands and distress caused by the
32 COVID-19 public health emergency (PHE) and its interoperability rule objectives.
- 33 b. Urge the ONC to earnestly consult with relevant stakeholders about unintended or
34 unforeseen consequences that may arise from the information blocking regulations.
- 35 c. Urge the ONC, through an interim final rule moratorium, to delay the current applicability
36 date of information blocking provisions until 12 months after the PHE is officially declared
37 over, affording small and medium-sized medical practices time to recover and prepare.
- 38 d. Urge the Department of Health and Human Services (HHS)’s ONC and their OIG to propose
39 future enforcement discretion that would afford small and medium-sized medical practices
40 further compliance flexibilities given their lack of resources.
- 41 e. Call on the HHS’s ONC and OIG in future enforcement rulemaking to propose corrective
42 action and further technical guidance rather than imposing fines or penalties.
- 43 f. Urge the ONC to broaden and relax its Patient Harm Exception through subregulatory
44 revisions that would include patients’ emotional and mental distress to the current and
45 narrow definition of this exception.
- 46 g. Call on the ONC to develop and offer more meaningful educational guidance, practical
47 resources, and technical assistance to physician practices to help them meet their
48 compliance efforts, patient care obligations and documentation requirements. (Directive to
49 Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Prioritization for J21 is sought in order to immediately request delay for compliance and clarification for information blocking provisions in the recently implemented 21st Century Cures Act. Practices are struggling to invest in the technology for immediate release of all medical information (e.g. notes, prescriptions, and lab tests, etc.) at the time of financial strain caused by the current COVID-19 public health emergency. The pandemic has put undue financial burden on physician practices, especially small practices. Unanticipated investment in information technology was required to quickly transition to telehealth services. Right now, it's an unreasonable time for practices to spend even more for information technology services to comply with information blocking regulations. Many practices, especially primary care practices, are operating with inadequate margins. A [survey](#) by the [Physicians Foundation](#) estimated that 8 percent of all physician practices nationally — around 16,000 — have closed under the stress of the pandemic. Advocating for an extension for compliance is timely so that practices can first get on their feet, recoup financial losses and then incorporate recommended changes.

RELEVANT AMA POLICY

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
 - (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
 - (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
 - (4) will continue efforts to promote interoperability of EHRs and clinical registries;
 - (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
 - (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
 - (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
 - (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
 - (9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
- Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep.

45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20;

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

Citation: BOT Rep. 19, A-18; Reaffirmation: A-19

1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include: (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit. (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment. (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists. AMA Principles of Medical Ethics: I,II,IV,VIII Issued: 2016

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(JUN-21)

Introduced by: Association for Clinical Oncology, American Academy of Ophthalmology,
American College of Rheumatology

Subject: CMMI Payment Reform Models

Referred to: Reference Committee B

1 Whereas, The 2020 Medicare Trustees Report projects that the Part A trust fund will become
2 insolvent in 2026; and
3

4 Whereas, Physicians in communities across the country and medical specialty societies are
5 developing innovative ways to reduce costs; and
6

7 Whereas, Cost-containment strategies should not limit the ability for patients to receive access
8 to appropriate care, or for providers to prescribe such care; and
9

10 Whereas, New approaches for care delivery and reimbursement should be tested through
11 multiple, voluntary demonstration projects to yield insights about the impact of the policy
12 changes and allow for public comment prior to broader implementation; and
13

14 Whereas, Different specialties' processes of care are as diverse as the range of problems they
15 address, such that a payment system that works well for one specialty would not fit another
16 specialty; and
17

18 Whereas, Communities have different cultures, economics, and levels of social support and
19 therefore a payment solution that works well in one community may not work well in another
20 community; and
21

22 Whereas, The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has
23 reviewed and assessed physician-focused payment models (PFPMs) based on stakeholder
24 proposals submitted to the committee, but the Center for Medicare and Medicaid Innovation
25 (CMMI) has not acted on their recommendations; and
26

27 Whereas, The Medicare Payment Advisory Commission (MedPAC) released a report in April
28 2021 recommending fewer models be offered by CMMI; and
29

30 Whereas, A new Administration creates opportunities to develop and test new models that
31 incentivize--not hamper--innovation that results in clinically meaningful improvements in patient
32 outcomes; therefore be it
33

34 RESOLVED, That our American Medical Association continue to advocate against mandatory
35 Center for Medicare and Medicaid Innovation (CMMI) demonstration projects (Directive to Take
36 Action); and be it further

1 RESOLVED, That our AMA advocate that the Centers for Medicare and Medicaid Services seek
2 innovative payment and care delivery model ideas from physicians and groups such as medical
3 specialty societies to guide recommendation of the Physician-Focused Payment Model
4 Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration
5 projects that are voluntary and can be appropriately tested (Directive to Take Action); and be it
6 further

7
8 RESOLVED, That our AMA advocate that CMMI focus on the development of multiple pilot
9 projects in many specialties, which are voluntary and tailored to the needs of local communities
10 and the needs of different specialties. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our AMA's current policy on Medicare demonstration projects focuses on including physicians and specialty societies in the development process of alternative payment models; however, it doesn't go far enough to make recommendations on the scale and scope of potential projects.

In recent months the Biden Administration has been pausing several prominent value-based reimbursement models run by CMS Innovation Center (CMMI) that had been approved and implemented by the Trump Administration in order to review model details. This intense audit of the previous administration's demonstration projects, coupled with the Medicare Payment Advisory Commission (MedPAC)'s April 2021 report recommending CMMI offer fewer models in the coming years, indicates that the new administration will likely put any newly proposed models through a longer and more rigorous review process prior to implementation. This provides a clear opportunity for our AMA to play an even more targeted role in shaping the proposals that will be considered.

If our AMA can seize on this opportunity to recommend that CMMI's newly proposed models focus on the development of multiple localized pilot projects across many specialties, we can help shape demonstration projects that physicians are incentivized to join voluntarily and that meet the needs of the communities they serve. This approach will be a benefit to care delivery across specialties and it is timely considering how early we still are in the new administration.

Above and beyond that, we need to begin the process now so that this new policy can be incorporated into our advocacy strategy. Given the timeliness and the low volume of projects that will be considered during the current administration, it is urgent that our AMA take up this resolution to ensure that future CMMI projects are voluntary and tailored to the needs of the specialized local communities that they serve.

The negative repercussions of demonstration projects that do not meet these requirements are likely long lasting and difficult to reverse.

¹ <https://fas.org/sgp/crs/misc/RS20946.pdf>

RELEVANT AMA POLICY

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
 4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance
 - b. Develop IT systems that support and streamline clinical participation
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
 5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
 6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode
 - b. Distinguish between services ordered by a physician and those delivered by a physician
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
 7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
 - a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.
- Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

Medicare Demonstration Projects D-330.948

Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians.

Citation: (CMS Rep. 3, A-05; Reaffirmed: CMS Rep. 1, A-15)

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
 2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
 3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
 4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
- Citation: Res. 241, A-16;

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
 2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
 3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
 4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
 5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
 6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
- Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

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 2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
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- Res. 241, A-16

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
 2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
 3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
 4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
 5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
 6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
- Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(JUN-21)

Introduced by: Medical Student Section

Subject: Status of Immigration Laws, Rules, and Legislation During National Crises
and Addressing Immigrant Health Disparities

Referred to: Reference Committee B

1 Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million
2 undocumented immigrants were living the United States¹; and
3

4 Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48
5 immigration policy changes that have not only affected international travel, student visas, and
6 immigration, and asylum processes, but also caused significant confusion for immigration
7 lawyers²⁻⁴; and
8

9 Whereas, The suspension of the United States Custom and Immigration Services (USCIS)
10 during the COVID-19 pandemic has led to a back-up in the processing of necessary
11 documentation, which has left many unable to access certain benefits necessary for work,
12 receiving healthcare, and accessing public benefits⁵; and
13

14 Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-
15 detained individuals on March 18, 2020, which delayed the processing of asylum seekers
16 enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary
17 conditions that promotes the spread of the virus⁵; and
18

19 Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create
20 rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both
21 entry at the northern and southern borders and barred asylum seekers from entering the country
22 due to public health threats, despite evidence suggesting that such restrictions are ineffective
23 and may even divert resources from other interventions⁵; and
24

25 Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed
26 hearings for detained people, prolonging their stay in detention centers^{4,5}; and
27

28 Whereas, The relief packages that were provided by the government during the pandemic either
29 provided little or no coverage to immigrants and their families, leaving them with few options for
30 testing and treatment^{5,7}; and
31

32 Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19
33 related services available under emergency Medicaid, which means that immigrants are unable
34 to access these services since they cannot apply for non-emergency Medicaid due to
35 immigration eligibility criteria^{1,5,8}; and
36

37 Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive
38 unemployment insurance or government stimulus checks during national crises^{5,9}; and

1 Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to
2 receive a stimulus payment to individuals with a social security number, which limits many
3 immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)^{1,5,8}; and
4

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

9 Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI)
10 programs, but due to lapses in work authorizations, many immigrants may either not qualify or
11 lose access to this vital benefit¹; and
12

13 Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule,
14 penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental
15 Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several
16 housing programs, and federal poverty level determination by threatening inadmissibility or
17 inability to be granted legal permanent residency in the United States^{10,11}; and
18

19 Whereas, These changes not only discourage use of publicly funded healthcare and welfare
20 services even among immigrant families to which the rule does not technically apply due to fear
21 and confusion, but also mislead countless immigrant parents to remove their U.S. citizen
22 children from health care insurance, likely leading to unnecessary child morbidity and
23 mortality^{10,12-15}; and
24

25 Whereas, Decreased participation in public benefit programs would contribute to a greater
26 uninsured population, a decrease in the use of both preventive and curative health services, and
27 negatively affect the health outcomes and financial stability of nearly 22 million noncitizens
28 currently residing in the U.S.^{10,16,17}; and
29

30 Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the
31 COVID-19 pandemic would not count as a public charge^{18,19}; and
32

33 Whereas, Although two filed lawsuits have prevented this ruling from being enacted further,
34 there remains a concern on the potential for future immigration policy to discriminate based on
35 poverty level, housing status, and the need for public benefits¹⁷⁻¹⁹; and
36

37 Whereas, Increased fear of deportation among families, even if only one family member is a
38 non-citizen immigrant, not only causes decreased health care utilization but also causes
39 increased behavioral issues in children¹⁷; and
40

41 Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law
42 and also recognize a responsibility to seek changes in those requirements which are contrary to
43 the best interests of the patient" [10]; and
44

45 Whereas, Our AMA is opposed to any proposed rule, regulations, or policy that would deter
46 immigrants and/or their dependents from utilizing non-cash public benefits including but not
47 limited to Medicaid, CHIP, WIC, and SNAP (AMA Policy D-440.927); and
48

49 Whereas, Our AMA joined other health care organizations in submission of amicus briefs and
50 comment letters opposing the new public charge regulations, stating "there is no evidence that
51 chilling the use of health and nutrition benefits will result in an increase in income, employment

1 or educational status of immigrants. These sweeping and detrimental changes will ultimately
2 result in far greater costs to the public's health than any purported benefit offered by DHS" [11];
3 and
4

5 Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants,
6 refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other
7 health care organizations in submitting amicus briefs and comment letters opposing the new
8 public charge regulations, stating "there is no evidence that chilling the use of health and
9 nutrition benefits will result in an increase in income, employment or educational status of
10 immigrants... These sweeping and detrimental changes will ultimately result in far greater costs
11 to the public's health than any purported benefit offered by DHS"¹¹; therefore be it
12

13 RESOLVED, That our American Medical Association, in order to prioritize the unique health
14 needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a
15 pandemic:

- 16 (1) oppose the slowing or halting of the release of individuals and families that are currently
17 part of the immigration process; and
- 18 (2) oppose continual detention when the health of these groups is at risk and supports
19 releasing immigrants on recognizance, community support, bonding, or a formal
20 monitoring program during national crises that impose a health risk; and
- 21 (3) support the extension or reauthorization of visas that were valid prior to a national crisis
22 if the crisis causes the halting of immigration processing; and
- 23 (4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum
24 status to immigrants, refugees, or migrant workers without a viable, medically sound
25 alternative solution (New HOD Policy); and be it further
26

27 RESOLVED, That our AMA amend H-350.957, "Addressing Immigrant Health Disparities," by
28 addition to read as follows:
29

30 Addressing Immigrant and Refugee Health Disparities H-350.957

31 1. Our American Medical Association recognizes the unique health needs of immigrants and
32 refugees and encourages the exploration of issues related to immigrant and refugee health
33 and supports legislation and policies that address the unique health needs of immigrants
34 and refugees.

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

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

44 4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities
45 among refugee or immigrant populations by forcing them to choose between health care or
46 future lawful residency status. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The recent proposal and implementation of actions like asylum seeker bans, refugee entry suspensions, and postponing of Migration Protection Protocol hearings clearly demonstrate the need for a strong stance on immigrant protections during states of national emergency. Our delegation considers immigrant health and protections to be our strongest priority and ranked this resolution accordingly. To ensure our asks are actionable, the language of our resolution was crafted with the assistance of AMA advocacy staff.

This resolution strengthens AMA policy on legal immigrants' right to health care. It also broadens current policy so the AMA can continue to engage in conversations on immigration policy and their impact on immigrant health. The AAP has released several policy statements on the treatment of immigrant and refugee children, especially as it pertains to the use of detention centers and family separation policies, demonstrating that it is appropriate for our AMA to update existing policies on these issues.

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RELEVANT AMA POLICY**Impact of Immigration Barriers on the Nation's Health D-255.980**

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

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906

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

Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957

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

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

Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901

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

CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

HIV, Immigration, and Travel Restrictions H-20.901

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

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

1 Whereas, Public assistance programs provide financial assistance to low-income individuals
2 and families to prevent falling below the poverty line due to costs of living, health care, and
3 food¹; and
4

5 Whereas, One in five Americans receives benefits from at least one public assistance
6 program¹; and
7

8 Whereas, Public assistance programs, like the Supplemental Nutrition Assistance Program
9 (SNAP), commonly known as “food stamps,” and the Temporary Assistance for Needy Families
10 (TANF), commonly known as “welfare,” provide financial assistance to low-income individuals
11 and families to address domestic hunger and similar basic needs²⁻³; and
12

13 Whereas, SNAP and TANF are partnerships where federal and state governments share
14 administrative responsibilities and expenses for beneficiaries^{2,3}; and
15

16 Whereas, SNAP usage is associated with improved nutrition, lower cost of health care among
17 recipients, and reduced risk for several chronic medical conditions including coronary artery
18 disease, cancer, asthma, and diabetes⁴; and
19

20 Whereas, Resource limitations and stringent requirements, such as federal law which requires
21 all TANF recipients work for a minimum of 30 hours per week or 20 hours per week for single
22 parents with children under the age of 6 years, prevent TANF from benefiting many low-income
23 families^{3,6}; and
24

25 Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation
26 in employment and training programs for certain adults aged 18 to 59⁵; and
27

28 Whereas, Efforts to increase work requirements for recipients of public assistance programs can
29 have negative effects on recipients’ health outcomes and limit their ability to find stable
30 employment⁶⁻⁷; and
31

32 Whereas, Many recipients register for public assistance programs only after losing employment,
33 and more than 80 percent report securing employment within a year after starting to receive
34 SNAP benefits⁶⁻⁷; and
35

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

1 Whereas, Increased work requirements to qualify for public assistance programs are not shown
2 to improve health outcomes or reduce employment barriers^{6,9}; and
3

4 Whereas, Both federal and state governments share authority over work requirements for public
5 assistance programs, and states can exempt recipients from federal work requirements at their
6 discretion to allow more individuals to benefit from public assistance programs^{2,5,10}; and
7

8 Whereas, Our AMA opposes work requirements for the public assistance program Medicaid¹¹;
9 and
10

11 Whereas, In a 2018 letter to the US Senate, our AMA expressed support for the preservation of
12 SNAP and opposed proposed increases in work requirements that would reduce benefits for
13 recipients¹²; and
14

15 Whereas, While AMA undertook this action, existing policy on SNAP is vague, stating that “Our
16 AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance
17 Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy
18 and productive lives” and does not explicitly describe our opposition to increasing work
19 requirements¹³; and
20

21 Whereas, In 2019, the US Department of Agriculture considered new regulations that would
22 remove SNAP benefits from hundreds of thousands of recipients, by preventing states from (1)
23 exempting recipients from SNAP work requirements, (2) expanding SNAP eligibility standards
24 beyond the federal minimum, and (3) automatically qualifying individuals for SNAP based on
25 TANF eligibility, all of which are efforts taken by states to expand benefits to more low-income
26 individuals¹⁴⁻¹⁶; therefore be it
27

28 RESOLVED, That our American Medical Association support reduction and elimination of work
29 requirements applied to the Supplemental Nutrition Assistance Program and the Temporary
30 Assistance for Needy Families Program (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA support states’ ability to expand eligibility for public assistance
33 programs beyond federal standards, including automatically qualifying individuals for a public
34 assistance program based on their eligibility for another program. (New HOD Policy)
35

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

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to support exemptions to work requirements and eligibility expansions in public assistance programs.

Our AMA already has policy opposing Medicaid work requirements, but does not have formal policy regarding work requirements for SNAP or other social support programs such as TANF. These programs already contain federally mandated work requirements, but states have traditionally been able to exempt beneficiaries from these requirements. States have also traditionally auto-qualified beneficiaries for SNAP based on their eligibility for TANF services to enroll individuals more easily in public assistance programs. Given prior attempts by the federal government to prevent states from taking these important actions, it is important to make an evidence-based AMA policy that supports work requirements exemptions for beneficiaries and easier access to public assistance programs.

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RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility. (Res. 802, I-17; Reaffirmation: A-18)

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

(Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18)

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

Our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include

additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, AMA-MSS Digest of Policy Actions/ 190 congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

(BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

1 Whereas, Under current federal law, any individual convicted of a drug-related felony is not
2 eligible for benefits under the Supplemental Nutrition Assistance Program (SNAP)¹; and
3

4 Whereas, This provision was originally part of a much larger welfare-reform package passed in
5 1996 to deter individuals from drug-related crimes and decrease misuse of the welfare system⁴;
6 and
7

8 Whereas, As of March 2019, only 3 states and territories currently maintain this lifetime ban, 24
9 states have modified this ban on SNAP for persons convicted of a drug-related felony, and 25
10 states have repealed this ban altogether^{2,3}; and
11

12 Whereas, Many state-based modifications to this ban entail limiting the classes of drug felonies
13 subject to restriction, creating short-term bans, requiring drug-testing for enrollees, and requiring
14 enrollment and participation in drug treatment programs⁵; and
15

16 Whereas, Based on a regression discontinuity analysis performed with data comparing
17 recidivism in convicted drug traffickers in Florida immediately before and after the institution of
18 the federal SNAP ban, banning access to SNAP has been associated with an increased
19 likelihood of criminal recidivism⁶; and
20

21 Whereas, An economic study examining administrative data on released offenders in 43 states
22 has found that eligibility for SNAP and Temporary Assistance for Needy Families (TANF) “at the
23 time of release from prison significantly reduces the risk of returning to prison within one year by
24 up to 10%”⁷; and
25

26 Whereas, Food insecurity is defined by the condition of households that, at times, were “unable
27 to acquire adequate food for one or more household members because they had insufficient
28 money and other resources for food”⁸; and
29

30 Whereas, 11.1% of American households reported experiencing food insecurity at least at some
31 point during 2018, while a pilot study with a sample size of 110 former drug offenders indicated
32 a food insecurity prevalence of 91%^{5, 9, 10}; and
33

34 Whereas, Food insecurity is associated with higher risk of chronic disease, including diabetes,
35 obesity, depression, and hypertension^{11,12}; and
36

37 Whereas, Access to SNAP benefits has been associated with improved health as indicated
38 subjectively by higher ratings of self-assessed health, with significantly increased probability of

1 reporting excellent or very good health, and objectively by fewer days in bed due to illness¹⁰;
2 and
3

4 Whereas, Evidence suggests that although SNAP participants have fewer office-based medical
5 visits overall, , they have more preventative checkups and fewer diagnostic or emergency visits
6 than non-participants¹³; and
7

8 Whereas, Existing AMA policy (H-270.966) opposes requiring SNAP applicants or beneficiaries
9 to disclose medical information, including former drug use and treatment history, and opposes
10 denying assistance from these programs based on substance use status, and also supports the
11 preservation of SNAP to increase access to healthful foods and decrease food insecurity (H-
12 150.937); and
13

14 Whereas, Current AMA policy does not address the impact of current federal law regarding
15 criminal drug offenses and subsequent access to SNAP benefits; therefore be it
16

17 RESOLVED, That our American Medical Association oppose any lifetime ban on SNAP benefits
18 imposed on individuals convicted of drug-related felonies. (New HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to oppose any federal lifelong ban on SNAP benefits for persons convicted of drug-related felonies given the potential for serious negative health and social consequences.

This resolution addresses a gap in AMA policy, and details why these individuals should not be restricted from accessing SNAP benefits once their sentence is concluded. SNAP is a program providing nutritional assistance to people who cannot afford it, and currently only persons convicted of drug-related felonies are subject to this federal ban--those convicted of murder, theft or other felonies can still get access to SNAP. Given that our AMA already supports SNAP, this policy is in-line with our belief that SNAP should be accessible to reduce food insecurity.

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RELEVANT AMA POLICY

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966

Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status. (Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res 203, A-16)

Improvements to Supplemental Nutrition Programs H-150.937

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

Whereas, The USDA Food and Nutrition Service (FNS) administers 15 federal nutrition-assistance programs across the country¹; and

Whereas, The National School Lunch Program (NSLP) and the School Breakfast Program (SBP), provide vital sources of food for low-income children during the school year¹; and

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

Whereas, The U.S. Department of Agriculture (USDA) National School Lunch Program, School Breakfast Program, and Child and Adult Care Food Program serve nearly 35 million children daily³; and

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

Whereas, Children automatically qualify for free meals if their household participates in the Supplemental Nutrition Assistance Program (SNAP), and they may be matched through other programs, such as the Temporary Assistance for Needy Families cash assistance program or the Food Distribution Program on Indian Reservations¹; and

Whereas, Schools and school districts that have at least 40 percent of students deemed automatically eligible for free lunch may participate in the Community Eligibility Provision (CEP), which allows schools to serve universal free meals without collecting household applications¹; and

Whereas, CEP allowed more than 13.6 million students in more than 28,000 schools to receive free lunch in the 2018–19 school year¹; and

Whereas, Based on an online survey (n=584), pick-up school-provided meals during the pandemic were received by 40.0% of families, while 27.8% received SNAP benefits, 11.7% received WIC benefits, and 16.5% received meals from local food banks or food assistance programs⁴; and

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

Whereas, Food insecurity is negatively associated with health outcomes, including poor mental health outcomes such as depression, stress, and anxiety, poor diet quality, high rates of chronic diseases such as diabetes and obesity, and a lower overall health status⁵; and

Whereas, The COVID-19 pandemic, and the associated social and economic responses have the potential to dramatically increase food insecurity and its related health disparities among already at-risk populations⁵; and

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

Whereas, Around 60.1% of families experienced a decrease in income during the pandemic, 23.4% of which were low food secure and 42.5% were very low food secure⁴; and

Whereas, Families that were already experiencing food insecurity before COVID-19 are more likely to have worsened insecurity during the pandemic, specifically 46.5% of these families experienced very low food security during this time⁴; and

Whereas, Individuals with low or very low food security are more likely to be non-Hispanic Black or Hispanic, be of lower socioeconomic status, have children in the home, not have health insurance or have Medicaid, and are more likely to be receiving SNAP benefits⁷; and

Whereas, This racial disparity in food security status is yet another example in which COVID-19 is disproportionately impacting minority and other marginalized communities in the United States⁷; and

Whereas, In comparison with 8% of white students, 45% of African American and Hispanic children attended high-poverty schools, where ≥75% of the student population have free or reduced-price lunch eligibility⁸; and

Whereas, Some solutions that have been enacted in order to provide meals for students that are not physically attending school have included waivers for school districts, such as allowing schools to serve meals outside of their standard times, that allow for expansion of normal meal assistance programs¹; and

Whereas, The increased need for meals and short time constraint of the pandemic have led to decreased reimbursement rates per meal, which only exacerbates the increased cost of these programs caused by staffing and delivery difficulties¹; and

Whereas, Some school districts offer the Summer Food Service Program (SFSP) and the Seamless Summer Option (SSO), which are typically used to continue serving meals to children during unanticipated school closures¹; and

Whereas, Despite various efforts to provide access to meals for families and children not at school, only 11% of newly unemployed families were reporting access to “grab-and-go” meals during the pandemic⁹; and

Whereas, The Pandemic Electronic Benefit Transfer (P-EBT) program was reauthorized in the Families First Coronavirus Act, and enables states to enact emergency standards of eligibility for children who have lost access to free- or reduced-price meals because their schools closed for at least five consecutive days in response to the COVID-19 pandemic¹; and

Whereas, The P-EBT program provides households for whom schools are closed for 20 days in a month a total benefit of \$115.60 per child¹; and

Whereas, Certain restrictions that exist for those using federal meal benefits, such as purchasing restrictions, may lead to decreased ability to purchase certain types of food or purchase food through some means¹⁰; and

Whereas, Available programs and offerings that the federal government have put in place have not been widely or equally adopted by states, leading to exacerbation of disparities on a geographical basis¹⁰; and

Whereas, Shifting the main responsibility of providing nutrition to children to the SNAP program may have negative health implications, since SNAP does not adhere to strict nutrition guidelines in the same ways that school meal programs must³; and

Whereas, There has not been a mandate released by the USDA to offer food service during school closures or for students who are not physically present at schools³; and

Whereas, The United States Food and Nutrition Service (FNS) released a statement that reaffirmed their commitment to allowing states to serve free meals to children, launching Pandemic-EBT (P-EBT), increasing SNAP benefits, addressing supply challenges, providing billions of dollars in food through local food banks, food pantries, and disaster household distributions, and approving nearly 3,000 flexibilities and program adjustments to ease operations and protect the health of applicants and participants¹¹; and

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

RESOLVED, That our American Medical Association amend policy H-150.962, “Quality of School Lunch Program,” by addition as follows:

Quality of School Lunch Program H-150.962

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

2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

3. Our AMA support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections for a social safety net, and this resolution addresses the issue of food insecurity for children during national emergencies. This resolution seeks to amend existing AMA policy H-150.962 to better address a gap in policy and allows our AMA to advocate for increased nutritional assistance programs.

The COVID-19 pandemic has certainly highlighted systemic inequalities, including food insecurity. Particularly in children, food insecurity has been shown to have adverse health and behavioral outcomes. The United States has seen an increase in food insecurity of almost 30% in households with children, a significant portion of which disproportionately impacts children of color, further contributing to the burden of disparities faced during this pandemic by communities of color. In a time such as a pandemic, when state and federal level nutrition and meal assistance programs are in high demand, the asks for increased funding and further advocacy supporting the adoption of these programs is warranted.

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RELEVANT AMA POLICY

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

Improvements to Supplemental Nutrition Programs H-150.937

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

Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.

Res. 921, I-18

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

1 Whereas, The United States government manages the largest immigration detention system in
2 the world¹; and
3

4 Whereas, The U.S. Customs and Border Patrol (CBP) and U.S. Immigration and Customs
5 Enforcement (ICE), both under the jurisdiction of the Department of Homeland Security (DHS),
6 are meant primarily to process non-US citizens (immigrants, migrants, and asylum seekers) and
7 the intention of their detention centers is to temporarily hold people until their cases are heard or
8 they are deported^{2,3}; and
9

10 Whereas, For ICE detention facilities, a 2019 report by DHS Office of the Inspector General
11 found 14,000 health and safety deficiencies mainly related to physical and mental health care
12 procedures for detainees⁴; and
13

14 Whereas, 23 deaths (42% of deaths) occurred due to substandard care in ICE immigrant
15 detention centers between 2010 and 2018⁵; and
16

17 Whereas, For CBP detention facilities, a 2019 report by DHS Office of Inspector General
18 showed that prolonged detention in overcrowded CBP facilities has resulted in unhealthy living
19 conditions, including sparse bathing and cleaning supplies, which has been confirmed by
20 attorneys of the detainees^{6,7}; and
21

22 Whereas, Increased duration of detention is associated with increased symptom severity with
23 respect to mental health conditions including post-traumatic stress disorder and depression⁸;
24 and
25

26 Whereas, No empirical evidence supports the assumption that the threat of being detained
27 deters irregular migration⁹; and
28

29 Whereas, Policy organizations across the political spectrum agree that there are viable
30 alternatives to immigrant detention centers overseen by the Department of Homeland Security
31 (DHS)¹⁰⁻¹²; and
32

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

1 Whereas, International program data on ATDs demonstrate improved health outcomes,
2 decreased costs, increased compliance with immigration check-ins and hearings, and preserved
3 family unity compared to detainment^{9,14,15}; and
4

5 Whereas, The United States Government Accountability Office reported that the daily cost of
6 ATDs is less than 7% of that of detention centers, thus ATDs cost less than seven cents for
7 every dollar required to operate detention centers¹⁵; and
8

9 Whereas, The FCMP also demonstrated that ATD programs could be more economic than
10 detention centers, costing approximately \$38.47 per family per day as compared to \$237.60 per
11 family per day¹⁶; and
12

13 Whereas, 99% of the 630 asylum seekers who participated in the Family Case Management
14 Program (FCMP), an ICE-run ATD program, complied with ICE monitoring requirements¹⁶; and
15

16 Whereas, Previously implemented ATD programs such as the Community Support Initiative and
17 the Appearance Assistance Program showed similarly high rates of compliance to FMCP^{12,17};
18 and
19

20 Whereas, The American Academy of Pediatrics, the American College of Physicians, and
21 Doctors for Camp Closure have recommended the use of ATD programs for immigrants, and
22 particularly for children^{18,19}; and
23

24 Whereas, ATD programs would achieve the healthcare quality goals of AMA policy D-350.983
25 for improving medical care in immigrant detention centers, and better align with our policy H-
26 65.965 on human dignity and human rights; and
27

28 Whereas, The term ATD is broadly defined and inclusive of alternatives that could be
29 considered exploitative or inhumane, such as applying high bail bonds or excessive
30 surveillance, thus creating a need to distinguish between ATD programs that respect human
31 dignity and those that do not¹⁰; and
32

33 Whereas, Our AMA supports “the dignity of the individual, human rights and the sanctity of
34 human life,” (H-65.965); therefore be it
35

36 RESOLVED, That our American Medical Association advocate for the preferential use of
37 Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and
38 asylum seekers who are in the custody of federal agencies. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The U.S. government manages the largest immigration detention system in the world, which is meant to temporarily hold non-US immigrants, migrants, and asylum seekers until their case is heard or until deportation. Alternatives to Detention Centers are defined, established programs that respect human dignity in a way that current detention centers do not by virtue of not placing undocumented immigrants in what amounts to jail cells and isolation from family and loved ones.

This resolution asks our AMA to support humane alternatives to detention centers, such as Intensive Supervision Appearance Program, Bonds, Family Case Management Program, and Community Management Programs. We request that the House of Delegates consider this resolution in light of COVID-19 and unsafe hygienic conditions that detainees are made to live in. Detention centers are ripe environments for spread of COVID-19 and other communicable diseases given crowding and poor hygiene.

Our delegation considers this resolution a priority due to the ongoing nature of this problem: if Our AMA HoD does not address this issue urgently, additional children will be taken from their mothers, additional families and additional detainees will suffer or die from unhygienic conditions. These alternative to detention programs are feasible, cheaper than current detention methods, more humane, and will not have the extensive negative impact on physical and mental health of immigrants and asylum seekers that detention does.

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RELEVANT AMA POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

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

Res. 017, A-17

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

Res. 002, A-17

Opposing the Detention of Migrant Children H-60.906

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

Res. 004, I-18

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14 Reaffirmed in lieu of: Res. 001, I-16 Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(JUN-21)

Introduced by: Medical Student Section

Subject: Oppose Tracking of People who Purchase Naloxone

Referred to: Reference Committee B

1 Whereas, The number of opioid deaths has been steadily increasing over the past two decades;
2 approximately 130 Americans die each day from opioid overdose¹; and
3

4 Whereas, Naloxone hydrochloride is a competitive antagonist against the mu-opioid receptor
5 that can be used to counteract the effects of opioids to reverse an overdose^{2,3}; and
6

7 Whereas, Due to the rising prevalence of opioid use disorder (OUD), the FDA approved the use
8 of naloxone products by bystanders who suspect opioid overdose⁴; and
9

10 Whereas, Naloxone has an established history of safe and effective use to combat opioid
11 overdoses and has no abuse potential^{5,6}; and
12

13 Whereas, Naloxone has few adverse effects and is very effective at reversing the actions of
14 opioids⁷; and
15

16 Whereas, When naloxone is given to healthy volunteers with no recent opioid
17 exposure, naloxone has no clinical effect, but when given to someone who is unresponsive for a
18 reason other than opioid toxicity, naloxone is unlikely to cause harm^{7,8}; and
19

20 Whereas, A prospective, randomized trial showed that intramuscularly or intranasally
21 administered naloxone showed low rates of minor adverse events (e.g. headache, nausea,
22 irritation) and major events (e.g. seizure) were not found⁶; and
23

24 Whereas, A systematic review on the management of opioid overdose with Naloxone reports
25 low rates of death or adverse outcomes (0% to 1.25%) for patients who were administered
26 naloxone and not brought to a healthcare facility⁹; and
27

28 Whereas, The World Health Organization (WHO) has recommended the widespread availability
29 of naloxone to counteract opioid related deaths¹⁰; and
30

31 Whereas, Take-home naloxone programs are effective for reducing opioid-overdose mortality,
32 and the efficacy of reversal by laypersons is 75-100%^{4,8}; and
33

34 Whereas, Between 1996 and 2014, 644 local sites in 30 states and the District of Columbia
35 distributed 152,000 naloxone kits and reported 26,000 successful drug overdose reversals¹¹;
36 and
37

38 Whereas, As of July 2017, all 50 states and the District of Columbia have passed laws that
39 increase public access to naloxone and 43 states have issued standing orders allowing non-
40 medical persons to obtain and administer naloxone^{12,13}; and

1 Whereas, Reviews have found that expanding the supply of naloxone is not associated with
2 compensatory drug use or greater risk-taking^{14,15}; and
3

4 Whereas, Many people who purchase and use naloxone are friends, family, and community
5 members who are not at risk of opioid overdose themselves, which means that the purchase of
6 naloxone is not indicative of overdose risk¹⁶⁻¹⁸; and
7

8 Whereas, Federal law (42 Code of Federal Regulations, Part 2) protects patient confidentiality
9 as it pertains to substance use treatment and does not require this information be placed in the
10 electronic medical record¹⁹; and
11

12 Whereas, Naloxone purchased without a prescription will be recorded at the pharmacy of
13 purchase²⁰; and
14

15 Whereas, The state of Nebraska maintains a prescription drug monitoring program, which will
16 track all dispensed prescriptions in the state including those for naloxone²⁴; and
17

18 Whereas, In Massachusetts, a state with a standing order allowing healthcare workers to
19 purchase naloxone, more than a half dozen employees at Boston Medical Center were denied
20 life and disability insurance due to receipt of naloxone; this is a problem that has occurred in
21 multiple states^{25,26}; and
22

23 Whereas, The presence of any evidence of substance use treatment including naloxone
24 purchases on a medical or insurance record may bias the provider and result in alteration of the
25 care provided²¹⁻²³; and
26

27 Whereas, Physicians who believe their patients have an OUD are less likely to provide them
28 with appropriate pain management and are more likely to assume symptoms are due to their
29 OUD²⁷; and
30

31 Whereas, There is no data to support that tracking naloxone purchase history provides any
32 health benefits, but it may reduce people's willingness to purchase naloxone^{25,28}; and
33

34 Whereas, Our AMA (H-95.932) along with the WHO and CDC respect recognize the importance
35 of increased access to naloxone and advocate for its widespread availability^{29,30}; therefore be it
36

37 RESOLVED, That our American Medical Association oppose any policies that require
38 personally identifiable information associated with naloxone prescriptions or purchases to be
39 tracked or monitored by non-health care providers. (New HOD Policy)
40

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution takes an important step to destigmatize the purchase of naloxone during the opioid crisis by proposing that the AMA support guidelines allowing any person be able to purchase naloxone without being tracked or monitored, and that the AMA oppose any policies that may require such prescriptions be tracked or monitored.

This resolution details the unnecessary tracking and monitoring of naloxone purchasing in certain states, how tracking naloxone purchases may discourage people from buying the life-saving drug, thus decreasing its accessibility. Because the AMA strongly supports the widespread availability and usage of naloxone to decrease the number of opioid related deaths (H-95.932) but has not yet taken a stance on potential tracking and monitoring of naloxone purchases, we believe that this resolution falls within the scope and spirit of the AMA and addresses an important gap in current policy.

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RELEVANT AMA POLICY

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. (BOT Rep. 22, A-16, Modified: Res. 231, A-17, Modified: Speakers Rep. 1, A-17, Appended: Res. 909, I-17, Reaffirmed: BOT Rep. 17, A-18, Modified: Res. 524, A-19)

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Res. 526, A-06, Modified in lieu of: Res. 503, A-12, Appended: Res. 909, I-12, Reaffirmed: BOT Rep. 22, A-16, Modified: Res. 511, A-18, Reaffirmed: Res. 235, I-18)

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947

Our AMA:

- (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
- (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
- (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperable, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
- (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
- (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
- (6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
- (7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
- (8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
- (9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs. (BOT Rep. 3, A-08, Reaffirmed: BOT Rep. 12, A-15, Reaffirmation: A-16, Appended BOT Rep. 13, A-17)

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will:

- (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial;
- (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and
- (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. (Res. 22, A-12, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15)

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

- A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
- B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard,

emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

- A. promotes physician training and competence on the proper use of controlled substances;
- B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
- C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
- D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81, Reaffirmed: CLRPD Rep. F, I-91, Reaffirmed: Sunset Report, I-01, Reaffirmed: CSAPH Rep. 1, A-11, Appended: Res. 907, I-11, Appended: Res. 219, A-12, Reaffirmation: A-15, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15, Reaffirmed: BOT Rep. 17, A-18, Modified: Speakers Rep., A-18)

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (BOT Rep. 11, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(JUN-21)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee B

Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and Immigration Services (USCIS) are as follows:

1. You must be a U.S. Citizen.
2. If you are unmarried, you must be at least 25 years old.
3. If you are married, you must jointly adopt the child (even if you are separated but not divorced), and your spouse must also be either a U.S. citizen or in legal status in the United States.
4. You must meet certain requirements that will determine your suitability as a prospective adoptive parent, including criminal background checks, fingerprinting, and a home study¹; and

Whereas, The federal government currently allocates funding for adoption and foster care to states, which independently manage federal funds and have differing statutes concerning eligibility to adopt or place a child up for adoption²⁻⁴; and

Whereas, Independent state-licensed child welfare agencies are contracted by each state to provide foster care or adoption services⁵; and

Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how “state-sanctioned discrimination against LGBT individuals who wish to raise children has dramatically increased in recent years”⁶⁻⁷; and

Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of children with LGBTQ individuals and same-sex couples and fourteen additional states lack explicit protection for LGBTQ individuals concerning adoption rights⁵; and

Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283 total children in the U.S. foster care system with 125,422 children waiting to be adopted⁸; and

Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the system⁸; and

Whereas, The longer a child is in foster care, the more likely that child is to move from one foster placement to another, and the greater the risk that child experiences adverse childhood events (ACEs), which may result in lasting negative social and emotional consequences⁹; and

1 Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster
2 care with no known internal or external problems show an increase in "total problem behavior" in
3 direct correlation with their number of placements¹⁰⁻¹²; and
4

5 Whereas, Frequent placement changes result in difficulty forming secure attachments with
6 foster parents, low-self esteem, and a negative relationship with academic growth¹⁰⁻¹²; and
7

8 Whereas, Per the Centers for Disease Control and Prevention, "Creating and sustaining safe,
9 stable, nurturing relationships and environments for all children and families can prevent ACEs
10 and help all children reach their full potential"¹³; and
11

12 Whereas, Recent social science literature supports that children living with same-sex parents
13 have equivalent outcomes compared to children with different-sex parents¹⁴; and
14

15 Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex
16 couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to
17 adopt children under age 18 compared to different sex couples¹⁵⁻¹⁶; and
18

19 Whereas, Current AMA Policy H-60.959 calls for the "comprehensive and evidence-based care
20 that addresses the specific health care needs of children in foster care" and supports the "best
21 interest of the child" as the most important criterion determining custody, placement, and
22 adoption of children;" and
23

24 Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of
25 their co-parenting partner but does not adequately address adoption rights of LGBTQ
26 individuals nor their limited eligibility or access to adoption, allowing for potential harm towards
27 children by narrowing the pool of qualified foster and adoptive homes; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for equal access to adoption
30 services for LGBTQ individuals who meet federal criteria for adoption regardless of gender
31 identity or sexual orientation (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA encourage allocation of government funding to licensed child
34 welfare agencies that offer adoption services to all individuals or couples including those with
35 LGBTQ identity. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution address equal access to adoption for the LGBTQ community. Our delegation believes it is imperative to continue to decrease the stigma and discrimination not only for those children who have yet to be adopted, but for the innumerable children parented by same-sex couples today. Moreover, there is also a vital function of a more equitable and available adoption process for same sex couples. By expanding the federal requirements for non-discrimination in relation to same sex parents, great strides could be made in addressing the epidemic of LGBTQ youth homelessness. Furthermore, the Supreme Court recently heard arguments on this very topic, experts believe the Supreme Court is likely to rule in favor of the Catholic adoption agency and thus against LGBTQ+ same sex parents/couples. This resolution would bolster existing AMA advocacy efforts.

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RELEVANT AMA POLICY**Uniformity of State Adoption and Child Custody Laws H-60.959**

The AMA urges: (1) state medical societies to support the **adoption** of a Uniform **Adoption** Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform **Adoption** Act; and (3) state medical societies to support **adoption** of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and **adoption** of children.

Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based **care** that addresses the specific health **care** needs of children in **foster care**.

Res. 907, I-17

Partner Co-Adoption H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973

It is the policy of the AMA to (1) support the provision of **adoption** information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of **adoption**.

Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by state and local courts to support individuals with mental illness in the justice system¹⁻⁷; and

Whereas, Mental health courts connect individuals with mental illness to mental health treatment, as an alternative to incarceration or other legal sentences and penalties¹⁻⁷; and

Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and resources in the justice system and to establish grants to fund mental health court programs⁸⁻⁹; and

Whereas, The continued funding of MIOTCRA programs over the last two decades has been dependent on Congressional appropriations¹⁰; and

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

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

Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals who come into contact with the criminal justice system appear” before municipal courts and “many of these individuals have mental illness and co-occurring substance use disorders,” municipal courts may be an especially effective “and often overlooked” method of diversion of individuals with mental illness from the justice system²⁶; and

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

Whereas, While several hundred mental health courts exist across all 50 states, mental health courts do not exist in all counties and localities, indicating that these programs may not be accessible or available to all individuals who could benefit from them⁴; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA¹⁰⁻¹², the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

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

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

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

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

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts³⁶⁻³⁷; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses³⁶; and

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

RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion to read as follows:

Support for ~~Mental Health Drug Courts~~, H-100.955

Our AMA: (1) supports the establishment and use of mental health drug courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports; (2) encourages legislators to establish mental health drug courts at the state and local level in the United States; and (3) encourages mental health drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

(Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to amend current AMA policy supporting the use of drug courts in a more expansive manner toward support of “mental health courts.” These are special courts comprised of judges, prosecutors, defense attorneys, and other personnel with expertise in mental health designed to rehabilitate persons with mental illness and decrease the percentage of persons with mental illness incarcerated without the appropriate treatment. Mental health courts have been shown to decrease recidivism, risk of violence, and re-hospitalization among individuals with mental illness in the justice system. Our delegation prioritizes behavioral health equity and parity. This resolution would ensure that individuals with mental illness involved in the justice system are connected to mental health services and are not unjustly incarcerated or oppressed due to a treatable and manageable illness.

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979

Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

Res. 202, I-19

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

Res. 116, A-12; Reaffirmation A-15

Support for Justice Reinvestment Initiatives, H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Res. 205, A-16

Prevention of Impaired Driving H-30.936 (excerpted)

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

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2

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

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

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

Decisions for Adult Patients Who Lack Capacity, E-2.1.2

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

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
 - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patient's views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
 - (i) the pain and suffering associated with the intervention;
 - (ii) the degree of and potential for benefit;
 - (iii) impairments that may result from the intervention;
 - (iv) quality of life as experienced by the patient.
- (f) Consult an ethics committee or other institutional resource when:
 - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
 - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
 - (iii) the physician judges that the surrogate's decision:
 - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
 - b. could not reasonably be judged to be in the patient's best interest; or
 - c. primarily serves the interests of the surrogate or other third party rather than the patient.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(JUN-21)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee B

1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime
2 rate taking place on rental properties by penalizing property owners if repeated incidents of
3 nuisance activity occur over a set period of time (typically, 12 months)¹; and
4

5 Whereas, CNOs are part of a phenomenon called “third-party policing,” through which cities
6 require private citizens – in this case property owners – to address criminal or otherwise
7 undesirable behaviors¹; and
8

9 Whereas, Punishments for violating CNO’s may range from warning letters and fines to
10 evictions and building closures, and often involve a “nuisance point system” where a certain
11 number of accumulated points will result in eviction and other actions¹; and
12

13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though
14 commonly defined as the amount of contact with emergency services, first responders, and
15 police, for criminal behavior that occurs on or near the property, or “alleged nuisance conduct”
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and
17 others)²; and
18

19 Whereas, CNO’s have been enacted by an estimated 2,000 municipalities across 44 states as
20 of 2014 ³; and
21

22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the
23 source, of the nuisance activity^{3,17}; and
24

25 Whereas, CNOs punish tenants who require police and emergency medical assistance by
26 making eviction a consequence of police responses to their homes¹; and
27

28 Whereas, The reason for calling the police is not taken into account by most CNOs, so people
29 who experience mental health crises may be deemed perpetrators of nuisance activity for
30 seeking emergency medical assistance at a frequency beyond the threshold established in the
31 CNO and may be threatened with eviction by their landlords¹; and
32

33 Whereas, Cities have fined group homes (organizations that provide community-based
34 residences for people with disabilities) after staff sought police or emergency services
35 assistance responding to their residents’ medical emergencies¹⁵; and
36

37 Whereas, Health crises that can count as a CNO violation include drug overdoses: public
38 records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are
39 related to a person experiencing a drug overdose, many of which explicitly include violations of
40 criminal drug abuse laws as nuisance¹⁵; and

1 Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as
2 litter, an un-mowed lawn, or an “unsightly” yard, which can be applied against residents whose
3 physical, mental, or health-related disabilities prevent them from meeting their municipality’s
4 maintenance standards¹; and
5

6 Whereas, In June 2017, an appellate court struck down the Village of Groton’s nuisance law as
7 unconstitutional under the First Amendment, the reasoning being that it deterred tenants from
8 seeking police assistance, and discouraged people, including domestic violence victims, from
9 reaching out for help⁴; and
10

11 Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that
12 chronic nuisance ordinances disproportionately impact people of color²; and
13

14 Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many
15 nuisance enforcement actions in the quarter of the city with the highest concentration of people
16 of color as it did in the quarter with the lowest concentration of people of color²; and
17

18 Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois
19 revealed that properties in predominantly black neighborhoods were more than twice as likely to
20 be cited under the city’s nuisance ordinance as white neighborhoods⁵; and
21

22 Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly
23 black neighborhoods were over two and a half times as likely to receive a nuisance citation as
24 properties in predominantly white neighborhoods, even when the neighborhoods made similar
25 numbers of calls⁶; and
26

27 Whereas, Women with disabilities have a 40% greater chance of experiencing domestic
28 violence than women without disabilities⁸; and
29

30 Whereas, There are an estimated 1.3 million women who are the victims of assault by an
31 intimate partner annually, and women have a 25% lifetime risk of intimate partner violence⁷; and
32

33 Whereas, Congress acknowledges that “women and families across the country are being
34 discriminated against, denied access to, and even evicted from public and subsidized housing
35 because of their status as victims of domestic violence” ⁷; and
36

37 Whereas, Domestic violence advocates’ efforts in the past decades have been focused on
38 educating law enforcement on how to approach and aid victims in escaping the cycle of
39 domestic violence while maintaining their housing³; and
40

41 Whereas, This initiative is directly being threatened by CNOs, as calls about domestic
42 disturbances can result in the eviction of everyone in the household^{3,10-13}; and
43

44 Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by
45 residents experiencing domestic violence even in cases where exceptions exist, calls placed by
46 survivors of domestic violence are regularly miscategorized and the tenants are punished under
47 the CNO regardless⁹; and
48

49 Whereas, Such punishment of domestic violence-related calls for police and medical services
50 discourages victims of domestic violence from seeking help in future assaults¹⁰; and

1 Whereas, The use of CNOs may contribute to the “double victimization” of domestic violence
2 victims, who may be evicted because of allegations of disturbing other tenants or property
3 damage caused by their abusers, and thus are more likely to hide the abuse rather than seek
4 help like emergency services¹¹; and

5
6 Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing
7 nuisance activity is limited^{6,9,12}; and

8
9 Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from
10 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such
11 behavior¹²; and

12
13 Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety,
14 and even suicide^{14,18}; and

15
16 Whereas, Individuals who lost legal rights to their housing and whose landlords applied for
17 eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to
18 individuals who had not experienced eviction¹⁶; and

19
20 Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or
21 victims of domestic violence limit the opportunities for these tenants to find affordable housing in
22 the future, regardless of the circumstances in which they occurred¹³; therefore be it

23
24 RESOLVED, That our American Medical Association advocate for amendments to chronic
25 nuisance ordinances that ensure calls made for safety or emergency services, are not counted
26 towards nuisance designations (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance
29 enforcement and (b) make that data publicly available to enable easier identification of
30 disparities. (New HOD Policy)

31
Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to advocate for changes in procedure to Chronic Nuisance Ordinances (CNOs) and to support initiatives that increase the data available on CNOs.

Cities across 44 states in the US have enacted Chronic Nuisance Ordinances (CNOs), which are municipal laws that penalize landowners and tenants when emergency services or law enforcement are called frequently to the premises. Importantly, CNOs in many municipalities do not distinguish between victims and perpetrators of nuisance activities. Numerous health crises can count as a CNO violation including drug overdoses, domestic or partner violence, and even mental health crises. As a consequence, tenants who require frequent police or emergency medical assistance may face threats of eviction and encounter discrimination when applying to housing. Thus, the enforcement of CNOs can penalize callers to the police and emergency services for assistance regardless of the situational context. CNOs are a serious detriment to our mission as physicians to “do no harm”. Our AMA should advocate for the amendment of CNOs to ensure that residents are not reprimanded in situations where they are victims.

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

1 Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical
2 treatment to their country of origin by healthcare professionals¹; and
3

4 Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign
5 country, provoking an unwarranted intersection between immigration enforcement and the
6 healthcare system²; and
7

8 Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017,
9 a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall
10 healthcare spending in a population with the highest risk of being uninsured among the non-
11 elderly population²⁻⁴; and
12

13 Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally
14 funded health institutions with emergency care capabilities are mandated to treat all patients
15 with emergent medical conditions who present to their facility until deemed stable, regardless of
16 their insurance coverage or financial status⁵; and
17

18 Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-
19 term care alternative is available to the patient as a cost-saving mechanism⁶; and
20

21 Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona
22 partake in forced medical repatriation for undocumented immigrant patients and a Florida
23 patient experienced involuntary deportation prior to the completion of their appeal or asylum
24 verdict⁷⁻⁹; and
25

26 Whereas, Forced medical repatriation has led to serious medical consequences for patients,
27 including the exacerbation of existing medical conditions^{10,11}; and
28

29 Whereas, Patients experienced a lapse and deterioration of care due to the inability of the
30 patient's country of origin to provide adequate treatment and concurrent separation from their
31 community in the U.S. during a time which may require emotional, physical and financial
32 support^{6,7,9,12}; and
33

34 Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical
35 consequences related to repatriation^{7,13}; and
36

37 Whereas, Forced medical repatriation increases health disparities among migrant communities
38 and deters immigrants from seeking necessary medical services^{14,15}; and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care^{16,17}; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum¹⁸; and

Whereas, The AMA *Journal of Ethics* encourages health care systems to seek routes of care to avoid forced medical repatriation and the AMA Code of Ethics Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations"^{2,19,20}; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)^{21,22}; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation^{7,23}; therefore be it

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The resolution denouncing the practice of forced repatriations in accordance to our ethical standards addressed a unique problem and proposes a change to existing policy. It clearly addresses an important ethical dilemma and public health crisis as a result of forced medical repatriations on our vulnerable immigrant communities and seeks to address forced medical repatriation by proposing an amendment to H-350.957. Currently, there is no mention of medical repatriation in existing AMA policies and under the current political climate revolving immigrant health, we feel that this obviously unethical practice urgently needs to be researched and denounced by our AMA. We believe that this is the natural progression of our nation's medical society towards caring for one of our most disenfranchised members of society.

By advocating for data collection and documentation of repatriation cases, this resolution also demands transparency into an issue that has been rendered invisible due to a lack of data. We believe that this resolution represents a timely and positive step forward during a time in which immigrant health has come under threat.

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RELEVANT AMA POLICY**Limit Scope of EMTALA to Original Legislative Intent D-130.994**

(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.

(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the

discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.

(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. (Sub. Res. 217, I-00, Reaffirmed: BOT Rep. 6, A-10)

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply. (BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17)

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18)

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950

Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements. (Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions; (2) make the PRO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. (Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10)

Repeal of COBRA Anti-Physician Provisions H-130.959

It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. (Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10)

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19)

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14)

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. (Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19)

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities. (Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

1 Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-
2 rays, which together are compared to growth charts to determine the age of an individual¹; and
3

4 Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs,
5 and dental X-rays may not correlate with the true chronological age of an individual due to
6 population and geography-specific factors, including nutritional intake, environmental exposure,
7 and genetics to such an extent that the Centers for Disease Control (CDC) recommends against
8 using hand-wrist radiographs to determine the age of refugees¹⁻⁵; and
9

10 Whereas, International records highlight the wide variety in growth charts utilized country to
11 country, in part due to different genetics, nutrition, medical conditions, and environmental
12 exposures^{6,7,8}; and
13

14 Whereas, The Department of Homeland Security (DHS) and the Department of Health and
15 Human Services (HHS) will request new skeletal and dental x-ray imaging to establish the age
16 of an individual crossing the border⁹; and
17

18 Whereas, According to Food and Drug Administration recommendations, performing x-rays on
19 children comes with greater risk of radiation-related illness and should only be used to answer a
20 clinical question or to guide treatment¹⁰; and
21

22 Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement, which
23 is part of HHS, states that medical images may be used only when no other means of verifying
24 chronological age exist^{9,11}; and
25

26 Whereas, The DHS handbook states that acceptable documentation to verify chronological age
27 can include official government-issued documents such as a birth certificate, other
28 governmental records, a baptismal certificate, school records, medical records, or other
29 objective documentation with a date of birth listed⁹; and
30

31 Whereas, If the immigrant/refugee does not have their birth certificate, the DHS handbook
32 states that affirmative steps should be taken to contact the refugee's home country's relevant
33 record keeping department to verify their birth date⁹; and
34

35 Whereas, The DHS handbook directs immigration officers to accept statements by the person in
36 question, their family members, other people who know the person as verifying evidence⁹; and
37

38 Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration
39 and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for

1 child age determination and has since decreased their use of age determination exams ^{12,13};
2 and
3

4 Whereas, In 2018, ICE decreased the number of age determination exams it used to less than
5 50; meanwhile, HHS increased its utilization of the exams for those in the care of the ORR to
6 almost 700 , almost double the number granted to both agencies in each of the prior two
7 years¹³; and
8

9 Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are
10 held in adult detention centers while waiting for their cases to be heard and therefore are not
11 held in the least restrictive setting, in violation of the federal government's promise to do so in
12 the Flores Agreement and further restricting their rights ¹⁴; and
13

14 Whereas, Attorneys representing minors report that their clients' supporting documentation was
15 not used and were instead placed in adult detention centers solely based on x-ray images for
16 months until federal judges ruled that ICE and HHS could not classify their immigrant clients as
17 adults based solely on imaging¹⁵; and
18

19 Whereas, As an example, one 19-year-old woman immigrating to the U.S. on a fiancée visa was
20 incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released
21 to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months¹⁶; and
22

23 Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare
24 services provided to minor immigrants, both in detention and those held at border patrol
25 stations; and
26

27 Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit
28 U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law
29 enforcement agencies from utilizing information from medical records to pursue immigration
30 enforcement actions against patients who are undocumented; therefore be it
31

32 RESOLVED, That our American Medical Association support discontinuation of the use of non-
33 medically necessary dental and bone forensics to assess an immigrant's age. (New HOD
34 Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections towards vulnerable and marginalized members in our society, including immigrants and refugees. This resolution addresses the inappropriate use of dental and bone X-rays in determining immigrant person's age. This resolution contains data suggesting bone and dental forensics are inadequate measures for determining age in immigrants crossing the US border who have other documentation, and the harm this practice causes. Not only can the unnecessary use of medical imaging increase radiation exposure to children but this technology has also been shown to be an imprecise and inaccurate method of age determination. There are current reports of minors being held in adult detention camps due to ICE policy that encourages the use of X Rays and dental records over self-reported or even documented age. We believe that this resolution represents a novel, and timely action taken on behalf of an incredibly vulnerable population and thus ask the House's consideration.

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RELEVANT AMA POLICY**Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958**

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. (Res. 013, A-19)

HIV, Immigration, and Travel Restrictions H-20.901

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

Patient and Physician Rights Regarding Immigration Status H-315.966

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Decreasing Financial Burdens on Residents and Fellows

Referred to: Reference Committee C

1 Whereas, Upon completion of medical school, trainees are often faced with significant financial
2 burdens. According to the annual AAMC Graduation Questionnaire, 52.6% of medical students
3 who graduated in 2019 had a combined premedical and medical school debt of \$150,000 or
4 more, with 26.2% reporting \$200,000-299,000.¹; and

5
6 Whereas, Between these financial restraints and 80-hour work weeks, trainees often struggle
7 with having the time and budget for necessities, such as childcare, meals, and transportation to
8 and from the hospital. When residency and fellowship programs provide benefits to assist with
9 these needs, it can significantly improve trainee wellbeing; and

10
11 Whereas, For trainees looking at residency and fellowship programs, information on benefits
12 offered by individual programs are essential to informed residency ranking. The recent 2019
13 expansion of the FREIDA database now includes the information requested in the RFS I-19
14 Report F recommendation.² Programs may report their employment policies and benefits, such
15 as on-site child care, on-call meal allowance, free parking, and housing stipend. This data is
16 collected through an AAMC survey of residency and fellowship programs, which has
17 approximately a 95% response rate; and

18
19 Whereas, Of the total 11,949 active residency and fellowship programs, 11,296 responded to
20 the survey. Of these, 7,566 (67%) indicated that they provide a meal allowance, 6,932 (61%)
21 provided free parking, 798 (7%) subsidized child-care, and 3,330 (29%) on-site childcare. The
22 number of programs offering each benefit varies widely between specialties, as can be seen in
23 the below graph. Summary reports with this data are published by the AAMC every year.³; and

24
25 Whereas, While strides have been made in providing more resources to trainees and increasing
26 transparency, there is clearly still much room for improvement in decreasing the financial burden
27 on residents and fellows; and

28
29 Whereas, Though the ACGME has extensive institutional requirements regarding work hours,
30 educational standards, and the provision of mental health resources, there are no standardized
31 guidelines for GME programs on policies like childcare or transportation assistance. It is up to
32 individual programs to decide what services to provide, leading to significant variance between
33 specialties, institutions, and programs; therefore be it

34
35 RESOLVED, That our American Medical Association work with the Accreditation Council for
36 Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC),
37 and other relevant stakeholders to advocate that medical trainees not be required to pay for
38 essential amenities and/or high cost or safety-related, specialty-specific equipment required to
39 perform clinical duties (Directive to Take Action); and be it further

1 RESOLVED, That our AMA work with relevant stakeholders including the AAMC to define
2 "access to food" for medical trainees to include 24-hour access to fresh food and healthy meal
3 options within all training hospitals (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees
6 have access to on-site and subsidized childcare (Directive to Take Action); and be it further
7

8 RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on
9 the AMA website and be disseminated to residency and fellowship programs (Directive to Take
10 Action); and be it further
11

12 RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be
13 amended by addition and deletion to read as follows:
14

15 5. Our AMA partner with ACGME and other relevant stakeholders to encourages
16 training programs to reduce financial burdens on residents and fellows by providing
17 employee benefits including, but not limited to, on-call meal allowances, transportation
18 support, relocation stipends, and childcare services. ~~teaching institutions to explore~~
19 ~~benefits to residents and fellows that will reduce personal cost of living expenditures,~~
20 ~~such as allowances for housing, childcare, and transportation.~~ (Modify Current HOD
21 Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The AMA has an extensive catalogue of policy on GME trainee protections. However, there have been some gaps in trainee protections that have become more salient as the average trainee is getting older and in areas where enforcement of ACGME requirements has been lacking. This collection of asks will help strengthen the protections for vulnerable populations, ask for child care coverage which is in line with current AMA actions, and ensure that as the costs of medical education increase, it does not do so at the expense of the trainee.

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2. <https://freida.ama-assn.org/Freida/#/>
3. <https://www.aamc.org/system/files/reports/1/2018stipendsurveyreportfinal.pdf>
<https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable

on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

Preserving Childcare at AMA Meetings G-600.115

Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings.

Citation: Res. 602, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee C

1 Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of
2 patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use
3 the title "physician."ⁱ; and
4

5 Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health
6 care advertising materials to clarify designate the level of education, skills and training of all
7 health care professionals promising their services"ⁱⁱ; and
8

9 Whereas, The Center for Medicare and Medicaid Services defines resident as "an intern,
10 resident, or fellow who is formally accepted, enrolled, and participating in an approved medical
11 residency program including programs in osteopathy, dentistry, and podiatry as required to
12 become certified by the appropriate specialty board"ⁱⁱⁱ; and
13

14 Whereas, There has been an increase in the number of physician assistant (PA) and nurse
15 practitioner (NP) postgraduate programs, many of which are inappropriately referred to as
16 "residencies" or "fellowships"^{ivvvi}; and
17

18 Whereas, On September 3, 2020 every major academic emergency medicine association
19 issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship'
20 in a medical setting must be limited to postgraduate clinical training of medical school physician
21 graduates within GME training programs"^{vii}; and
22

23 Whereas, Several of these training programs pay their first-year trainees more than the first-
24 year residents in physician residencies^{viii}; therefore be it
25

26 RESOLVED, That our American Medical Association believe that healthcare trainee salary,
27 benefits, and overall compensation should, at minimum, reflect length of pre-training education,
28 hours worked, and level of independence and complexity of care allowed by an individual's
29 training program (for example when comparing physicians in training and midlevel providers at
30 equal postgraduate training levels) (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor,"
2 "Resident" and "Residency," by addition and deletion to read as follows:

3
4 Our AMA:

5 (1) recognize that the terms "medical student," "resident," "residency," "fellow,"
6 "fellowship," "physician," and "attending," when used in the healthcare setting, all
7 connote completing structured, rigorous, medical education undertaken by physicians,
8 as defined by the Centers for Medicare and Medicaid Services, and thus these terms
9 must be reserved only to describe physician roles; (2) advocate that professionals in a
10 clinical health care setting clearly and accurately identify to patients their qualifications
11 and degree(s) attained and develop model state legislation for implementation; (3)
12 supports and develop model state legislation that would penalize misrepresentation of
13 one's role in the physician-led healthcare team, up to and including to make it a felony
14 to misrepresent oneself as a physician (MD/DO); and (4) support and develop model
15 state legislation that calls for statutory restrictions for non-physician post-graduate
16 diagnostic and clinical training programs using the terms "medical student," "resident,"
17 "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting
18 except by physicians. (Modify Current HOD Policy); and be it further

19
20 RESOLVED, That our AMA study and report back, by the 2022 Annual Meeting, on curriculum,
21 accreditation requirements, accrediting bodies, and supervising boards for graduate and
22 postgraduate clinical training programs for non-physicians and the impact of non-physician
23 graduate clinical education on physician graduate medical education (Directive to Take Action);
24 and be it further

25
26 RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the
27 expansion of post-graduate clinical training for non-physicians do not divert funding from
28 physician GME (Directive to Take Action); and be it further

29
30 RESOLVED, That our AMA partner with the Accreditation Council for Graduate Medical
31 Education (ACGME) to create standards requiring Designated Institutional Officials to notify the
32 ACGME of proposed training programs for physicians or non-physicians that may impact the
33 educational experience of trainees in currently approved residencies and fellowships (Directive
34 to Take Action); and be it further

35
36 RESOLVED, That policy H-310.912 "Resident and Fellow Bill of Rights," be amended by
37 addition and deletion to read as follows:

38
39 B. Appropriate supervision by qualified physician faculty with progressive resident
40 responsibility toward independent practice. With regard to supervision, residents
41 and fellows ~~should expect supervision by physicians and non-physicians~~ must be
42 ultimately supervised by physicians who are adequately qualified and ~~which~~ allows
43 them to assume progressive responsibility appropriate to their level of education,
44 competence, and experience. ~~It is neither feasible nor desirable to develop~~
45 ~~universally applicable and precise requirements for supervision of residents.~~ In
46 instances where clinical education is provided by non-physicians, there must be an
47 identified physician supervisor providing indirect supervision, along with
48 mechanisms for reporting inappropriate, non-physician supervision to the training
49 program, sponsoring institution or ACGME as appropriate. (Modify Current HOD
50 Policy); and be it further

1 RESOLVED, That our AMA distribute and promote the Residents and Fellows' Bill of Rights
2 online and individually to residency and fellowship training programs and encourage changes to
3 institutional processes that embody these principles (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on
6 the board of an organization that regulates and/or provides oversight of physician
7 undergraduate and graduate medical education, accreditation, certification, and credentialing
8 when these types of non-physician healthcare providers either possess or seek to possess the
9 ability to practice without physician supervision as it represents a conflict of interest.
(Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

We present this Scope of Practice concern from the RFS for consideration by the HOD in lieu of others as this policy will have the greatest impact. The resolved clauses encourage a higher standard for our allied health colleagues in specialty fields, equal pay for trainees for equal work compared to the PA and NP colleagues we work side-by-side with, and a biennial study to track non-physician provider training standards and oversight. This is a worthwhile discussion that affects all areas of medicine. Given the recent ACEP report on the EM workforce and the influence of non-physicians on the workforce without specialty training, this issue is timely not only to those currently in training, but to the future of the profession. We cannot wait to be reactive when our patients and our profession are at stake.

ⁱ <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>

ⁱⁱ <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>

ⁱⁱⁱ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>

^{iv} <https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps>

^v <https://appap.org/wp-content/uploads/2020/03/APPAP-Postgraduate-Program-Membership-Roster-by-Specialty-March-2020.pdf>

^{vi} 12. Association of Postgraduate Physician Assistant Programs. APPAP programs by specialty. Accessed at <http://appap.org/Programs/tabid/58/Default.aspx> on January 30, 2010.

⁷ <https://architectinperson.wordpress.com/2011/11/16/stop-calling-me-the-intern/>

^{vii} <https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/>, accessed 9/12/2020

^{viii} <https://med.dartmouth-hitchcock.org/pa-residency/ccappresidency.html>

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

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of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

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With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations,

and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

H-275.925 Protection of the Titles "Doctor," "Resident" and "Residency"

Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO).

Sub. Res. 232, A-08; Reaffirmation I-09; Reaffirmed: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 09, A-19

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and

(c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19

H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

D-35.996 Scope of Practice Model Legislation

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners.

Res. 923, I-03 Reaffirmed: BOT Rep. 28, A-13

H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

-
- (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
- (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
- (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
- (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
- CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13*

Code of Medical Ethics: 10.5 Allied Health Professionals

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

- (a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
- (b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
- (c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.

AMA Principles of Medical Ethics: I, V, VII

D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11

D-275.979 Non-Physician "Fellowship" Programs

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14

D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave during Graduate Medical Education Training

Referred to: Reference Committee C

1 Whereas, A substantial number of trainees become parents during their training as a resident or
2 fellow; and
3

4 Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a
5 12-month employment eligibility threshold; and
6

7 Whereas, Unlike other industries, such as technology and law, “there is no standardized
8 approach to parental leave across GME programs”¹; and
9

10 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not
11 establish minimum standards for duration of parental leave for trainees; and
12

13 Whereas, A lack of minimum national standards may result in some trainees receiving
14 substandard resources and benefits²; and
15

16 Whereas, Current AMA policy (H-405.960) encourages residency programs, among other
17 stakeholders, to incorporate a “six-week minimum leave allowance;” therefore be it
18

19 RESOLVED, That our American Medical Association support current efforts by the Accreditation
20 Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties
21 (ABMS), and other relevant stakeholders to develop and align minimum requirements for
22 parental leave during residency and fellowship training and urge these bodies to adopt minimum
23 requirements in accordance with policy H-405.960 (Directive to Take Action); and be it further
24

25 RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue
26 burden on trainees related to parental leave (Directive to Take Action); and be it further
27

28 RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to
29 develop specialty specific pathways for residents and fellows in good standing, who take
30 maximum allowable parental leave, to complete their training within the original time frame.
31 (Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. Specifically, the ACGME is actively working on this and not having AMA policy on an issue that affects a significant number of trainees while discussions are actively being had by decision makers makes this policy particularly relevant and timely. This policy applies to current and all future physician trainees.

References:

1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. *Am J Med.* 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

RELEVANT AMA POLICY

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.**

Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common

and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning

maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Reference Committee C

Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and wellness strategies (291.015R); and

Whereas, This same policy was reaffirmed at I-18 (291.036R); and

Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does include program requirements for specific aspects, but is unclear about what satisfies those requirements¹; and

Whereas, New data exists regarding the efficacy of various specific burnout prevention strategies²⁻⁷; and

Whereas, Some organizations such as Stanford Medicine have been leaders in the field of physician wellness and burnout prevention through research, novel approaches and curriculum and support such as House Staff Wellbeing Panel and it may be prudent to apply these strategies into ACGME common requirements of residency programs⁸; and

Whereas, These specific strategies may be a more effective way to mitigate burnout than the current ACGME policy as listed; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

Although there is much focus on wellness in the era of COVID-19, this has been a long-standing concern for which too little has been done to affect change, and it is now taking its toll. Although this is less urgent due to the declining pandemic, medicine has struggled with how to address burnout and sustain wellness for years and there is no better place to begin to address this than at the GME level.

References:

1. "Common Program Requirements." ACGME, Accreditation Council for Graduate Medical Education, <https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>.
2. [Mindfulness therapies on health professionals](#). Ruiz-Fernández MD, Ortiz-Amo R, Ortega-Galán ÁM, Ibáñez-Masero O, Rodríguez-Salvador MDM, Ramos-Pichardo JD. Int J Ment Health Nurs. 2019 Sep 9. doi: 10.1111/inm.12652. [Epub ahead of print] Review. PMID: 31498549
3. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. J Gen Intern Med. 2015;30(4):508–513. doi:10.1007/s11606-014-3144-y
4. [Doctor, how can we help you? Qualitative interview study to identify key interventions to target burnout in hospital doctors](#). Walsh G, Hayes B, Freney Y, McArdle S. BMJ Open. 2019 Sep 5;9(9):e030209. doi: 10.1136/bmjopen-2019-030209. PMID: 31492785
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7. [The effects of playing music on mental health outcomes](#). Wesseldijk LW, Ullén F, Mosing MA. Sci Rep. 2019 Aug 30;9(1):12606. doi:10.1038/s41598-019-49099-9. PMID: 31471550
8. <https://wellmd.stanford.edu/>

RELEVANT AMA POLICY**Code of Medical Ethics****9.3.1 Physician Health & Wellness**

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse.

Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968

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

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

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

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

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(JUN-21)

Introduced by: Pennsylvania

Subject: Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination
Requirement for Medical Licensure

Referred to: Reference Committee C

1 Whereas, The 2020 registration fee for the United States Medical Licensing Exam (USMLE)
2 Step 2 Clinical Skills (CS) exam is \$1,300 (1); and
3

4 Whereas, The 2020 registration fee for the Comprehensive Osteopathic Medical Licensing
5 Examination (COMLEX) Level 2 Performance Evaluation (PE) exam is \$1,295 (9); and
6

7 Whereas, Students incur additional travel and lodging expenses to take the Step 2 Clinical
8 Exam in one of five locations across the country or to take the COMPLEX Level 2 PE exam in
9 one of two locations (2,10); and
10

11 Whereas, The average medical school debt for class of 2019 graduates in the United States
12 (U.S.) was \$201,490 (8); and
13

14 Whereas, The Liaison Committee on Medical Education and Commission on Osteopathic
15 College Accreditation ensure standards of clinical proficiency by students attending U.S.-
16 accredited MD and DO programs, respectively (3,4); and
17

18 Whereas, Scores on USMLE Step 2 CS exams are not predictive of intern clinical skills
19 performance (6); and
20

21 Whereas, There is a lack of data on usefulness USMLE Step 2 CS exam results provide (6);
22 and
23

24 Whereas, USMLE Step 2 CS is a costly method of evaluating clinical skills and adds little value
25 to the U.S. healthcare system (7); and
26

27 Whereas, Existing American Medical Association (AMA) policy, last affirmed in 2019, commits
28 to working with appropriate stakeholders, including state medical boards, to replace USMLE
29 Step 2 CS and COMLEX Level 2 PE exams (5); and
30

31 Whereas, Existing AMA policy commits to timely changes in the clinical skills examination
32 process to reduce cost to medical students (5); and
33

34 Whereas, Existing PAMED policy supports the elimination of the USMLE Step 2 CS and
35 COMLEX Level 2 PE exams, with the creation of standards for a clinical schools exam to be
36 held at accredited medical or osteopathic schools (13); and
37

38 Whereas, These two examinations have been administratively suspended during the pandemic:
39 USMLE Step 2 CS till June 2021 and COMLEX Level 2 PE till November 2020 (11,12); and

Whereas, Existing approaches for addressing this have focused on the Federation of State Medical Board (FSMB); and

Whereas, Advocacy targeting FSMB on this issue has not yielded resolution of this matter; and

Whereas, While the Covid pandemic has resulted in the cessation of both exams, at the present there is concern that as the pandemic eases one or both of these exams may be resurrected either in their previous form or in some new modified version in the near future; therefore be it

RESOLVED, That our American Medical Association work to rescind USMLE Step 2 CS and COMLEX Level 2 PE examination requirements and encourage a “fifty-state approach” by all individual state medical societies to engage with their respective state medical boards on this issue. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution is listed as only a high priority and not a top priority since it's impact is not on all physicians. Yet it is of top importance to those individuals for which these exams apply. The reason that this resolution is not reaffirmation is that this resolution seeks the AMA to approach this problem in a new direction. Working with individual state societies can help withdraw the sense that these exams are an appropriate evaluation criteria. Even if only 1/4 of the individual states withdraw this requirement from their individual state boards there will be increased pressure on other state boards to fall in line.

The question as to whether it is better to continue to have the AMA to continue to work from a top down approach on this and other issues will be determined by how easy and or successful we are with a decentralized “fifty state” approach that is coordinated and lead by the AMA

References:

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2. <https://www.csecassessments.org/test-centers/>
3. <https://lcme.org/about/>
4. <https://osteopathic.org/accreditation/accreditation-guidelines/>
5. AMA policy as below, D-295.988
6. Flier LA, Henderson CR, Treasure CL. Time to Eliminate the Step 2 Clinical Skills Examination for US Medical Graduates. JAMA Intern Med. 2016;176(9):1245–1246. doi:10.1001/jamainternmed.2016.3753
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9. <https://www.nbome.org/exams-assessments/comlex-usa/comlex-usa-level-2-pe/registration-scheduling/>
10. <https://www.nbome.org/exams-assessments/comlex-usa/comlex-usa-level-2-pe/locations-travel/>
11. <https://www.usmle.org/announcements/?ContentId=266>
12. <https://www.nbome.org/uncategorized/important-notice-regarding-covid-19-coronavirus/>
13. <https://www.pamedsoc.org/docs/librariesprovider2/pamed-documents/pamed-downloads/HODAEC/> 16-205.pdf

RELEVANT AMA POLICY

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
 3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
- Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(JUN-21)

Introduced by: Pennsylvania

Subject: Supporting GME Program Child Care Consideration During Residency Training

Referred to: Reference Committee C

1 Whereas, Residency training often occurs during one's childbearing and child-rearing years
2 while residents concurrently work long hours with unpredictable, demanding schedules,
3 necessitating childcare for those residents who are parents, especially women (1); and
4

5 Whereas, On-site, extended-hour, and/or drop-in child care is desired by both male and female
6 residents because it allows residents (a) more frequent contact with their children, (b) reduced
7 stress and anxiety with scheduling of work and children's needs, and (c) decreased utilization of
8 parental and/or FMLA leave policies, providing net financial benefit to the healthcare provider
9 facility through tax benefits and increased resident productivity (2, 3, 4, 5, 6, 7); and
10

11 Whereas, Childcare costs are financially burdensome. In the northeast, the overall annual
12 household cost of childcare was \$24,815 in 2017 for a family with two children. In
13 Pennsylvania, the cost of individual part-time center-based child care was \$7,148 which is
14 ranked as the highest in the nation and itself exceeds the 7% household child care expense
15 share of income for residents and fellows – as recommended by the United States Department
16 of Health and Human Services; this cost comes at a time when most residents also begin
17 repayment of their cumulative higher education student loan debt which compounds the
18 financial burdens faced by residents (8, 9, 10); and
19

20 Whereas, Childcare resources available to residents are inconsistent between graduate
21 medical education residency program host institutions. A national survey of graduating
22 pediatric residents found that only 24% reported access to on-site childcare at their training
23 institution, 19% reported access to sick-child care, and 9% received subsidies for childcare
24 expenses (11). In a survey of pediatrics department chairs, 59% indicated that on-site childcare
25 or assistance with finding childcare was available at their institution for residents, but 50%
26 responded that demand for childcare always or almost always exceeded availability (12). In a
27 survey of general surgery program directors, 40% indicated on-site childcare at their facility
28 with residents facing enrollment waiting lists and challenges scheduling for pick-up and drop-off
29 (13). Similar findings have been recently described in a survey among obstetrics and
30 gynecology residency program directors (14); and
31

32 Whereas, Childbearing and child-rearing responsibilities are disproportionately burdensome
33 upon women in the United States, regardless of occupation (15); and
34

35 Whereas, Surgery residents who report perceiving stigma during pregnancy practiced at
36 institutions that did not have a formal institutional maternal leave policy or were required to alter
37 training plans (16); and

Whereas, Supportive childcare policies may enable more equity for female physician career advancement and contribute to a wider variety of specialty choices. In a study conducted at Stanford University School of Medicine, female physicians ranked flexible working environments – with particular regard to childcare, including emergency childcare on-site or nearby – as the highest priority and most important need to improve their career success and well-being (17). Likewise, in a survey of general surgery residency program directors, 61% of directors indicated that having children negatively affects female trainees' work and places an increased burden on colleagues (18); therefore be it

RESOLVED, That our American Medical Association convene a group of interested stakeholders to examine the need for innovative childcare policies and flexible working environments for all residents in order to promote equity in all training settings. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Pennsylvania Delegation would appreciate the committee considering its Resolution A-20, "Supporting GME Program Child Care Consideration During Residency Training," to be "Medium Priority" for the upcoming June HOD. There is a marked overlap between the usual residency training period and the optimal years for childbearing and rearing. Residents are often faced with not only long and demanding work schedules but childcare costs that are financially burdensome and often occur simultaneous with the repayment of student loans. Further, these responsibilities often fall disproportionately on female residents and resources available to residents are inconsistent and often inadequate. Supportive policies for childcare will promote greater equity, inclusion and career advancement for females in all GME programs as reflected in a study from Stanford. As an example of educational needs for training programs, a recent survey of program directors in general surgery residencies noted that, "having children negatively affects female trainees' work and places and increased burden on colleagues". This stigmatizing of female trainees is not only traumatizing to the trainees but also sets a terrible example for others. We believe that it is in the best interest of the AMA as well as US medicine to address this important topic now and work diligently to remove this unnecessary burden on our junior colleagues.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(JUN-21)

Introduced by: Pennsylvania

Subject: Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (ABIM)

Referred to: Reference Committee C

1 Whereas, Our American Medical Association has noted the heavy financial and emotional toll
2 that the Maintenance of Certification (MOC) programs of some of the American Board of
3 Medical Specialties Boards (ABMS) have had on physicians; and
4

5 Whereas, Many physicians are certified by more than one ABMS Board but participate in MoC
6 with only one of those boards, and
7

8 Whereas, The ABIM, while recognizing that some ABIM certified physicians hold and maintain
9 board certification by a board other than the ABIM, and
10

11 Whereas, The ABIM charges such physicians a fee which is nearly as high as that charged
12 physicians maintaining certification with the ABIM, and
13

14 Whereas, The ABIM refuses to accurately reflect such physicians' status as "Participating in
15 MOC" in the ABIM Directory unless they pay that fee, therefore be it
16

17 RESOLVED, That our American Medical Association work with the American Board of Medical
18 Specialties Boards (ABMS), in general, and American Board of Internal Medicine (ABIM),
19 specifically, to require the ABIM stop charging physicians with two or more board certifications,
20 who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to
21 accurately list their current board status in the ABIM Directory. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Over the last several sessions our AMA has been presented issues of MOC and recertification. This resolution focuses on issues of multiple board certifications, expenses of certification and discrepancies with accurately listing of physician status by the ABMS and the ABIM specifically.

The resolution asks that the AMA stop the ABMS and the ABIM from multiple charges for physicians with more than one board certification and to have the ABIM accurately list a physician participating in MOC with other boards and list their board status as such without paying full fee to the ABIM.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(JUN-21)

Introduced by: Illinois

Subject: Student Loan Forgiveness

Referred to: Reference Committee C

1 Whereas, The cost of medical education, all facets included, is a significant burden for resident
2 physicians as well as for young physicians beginning practice; and
3

4 Whereas, Such costs and burdens significantly influence medical specialty and location of
5 practice selection and it is widely thought that this limits the numbers of students selecting
6 primary care specialties; and
7

8 Whereas, The Public Service Loan Forgiveness Program, a federal program, allows payment
9 for 10 years against the loan balance then the application for loan forgiveness of the remaining
10 loan amounts at that point; and
11

12 Whereas, 98% of applications for loan forgiveness under the Public Service Loan Forgiveness
13 Program are denied; therefore be it
14

15 RESOLVED, That our American Medical Association study the cause for the unacceptably high
16 denial rate of applications made to the Public Health Services Student Loan Forgiveness
17 Program, and advocate for improvements in the administration and oversight of the Program,
18 including but not limited to increasing transparency of and streamlining program requirements;
19 ensuring consistent and accurate communication between loan services and borrowers; and
20 establishing clear expectations regarding oversight and accountability of the loan servicers
21 responsible for the program. (Directive to Take Action)

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

Received: 05/11/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is both urgent and high priority. Medical school debt loads are reaching crisis levels, and the high cost of medical education is significantly impacting the size and distribution of the physician work force. The Public Health Services Student Loan Forgiveness program was supposed to be a lifeline for medical students, but the denial rates under the program have been astronomical, clearly an indication of poor communication and implementation of program requirements. It is critical that this issue be addressed as soon as possible so that students who adhere to the service requirements of program are able to access the loan terms they were promised.

References:

<https://students-residents.aamc.org/financial-aid/article/public-service-loan-forgiveness-pslf/>
<https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html>

RELEVANT AMA POLICY**H-305.925 - Principles of and Actions to Address Medical Education Costs and Student Debt**

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
- ...
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the

interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

...

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(JUN-21)

Introduced by: American College of Preventive Medicine
American College of Occupational and Environmental Medicine
American Association of Public Health Physicians

Subject: AMA Support for Increased Funding for the American Board of Preventive
Medicine (ABPM) Residency Programs

Referred to: Reference Committee C

1 Whereas, The AMA mission statement supports the betterment of public health; and

2
3 Whereas, The American Board of Preventive Medicine is the Board responsible for certification
4 of the skills, knowledge and professional acumen of physicians in specialties of Aerospace
5 Medicine, Occupational and Environmental Medicine, and Public Health & General Preventive
6 Medicine, and subspecialties including Undersea & Hyperbaric Medicine, Medical Toxicology,
7 Clinical Informatics and Addiction Medicine; and

8
9 Whereas, These specialties and subspecialties are the core residencies of training for future
10 public health physicians and leaders in this country; and

11
12 Whereas, The COVID-19 pandemic has clearly emphasized the imperative for trained public
13 health leadership to ensure proper preparedness and response in the US; and

14
15 Whereas, The COVID-19 pandemic has raised the awareness of a shortage of physician trained
16 to address prevention, preparedness, response, recovery, and resiliency in rural communities
17 across America; and

18
19 Whereas, Funding support for preventive medicine specialties is not generally understood nor
20 offered through traditional sources from the Centers for Medicare and Medicaid Services (CMS);
21 and

22
23 Whereas, Variable funding comes from Health Resources and Services Administration (HRSA),
24 Centers for Disease Control and Prevention (CDC), National Institutes of Occupational Safety
25 and Health (NIOSH) and the Defense Act; and

26
27 Whereas, These residency programs continually lack sufficient funding to fill the slots available
28 and financially support the training for this important aspect of the health care workforce;
29 therefore be it

1 RESOLVED, That our American Medical Association support and advocate for increased
2 funding through the Health Resources and Services Administration (HRSA), National Institute
3 for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention
4 (CDC), and other mechanisms for all residencies training physicians in the Preventive Medicine
5 specialties of Aerospace Medicine, Occupational and Environmental Medicine and Public Health
6 & General Preventive Medicine, and subspecialties including Undersea & Hyperbaric Medicine,
7 Medical Toxicology, Clinical Informatics and Addiction Medicine (Directive to Take Action); and
8 be it further

9
10 RESOLVED, That our AMA actively increase further awareness of the importance of public
11 health training, leadership, and principles among all medical students and physicians in training
12 and in practice. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We are public health. We are the Section Council on Preventive Medicine (SCPM), the conscience of public health in the American Medical Association (AMA) House of Delegates. The mission of AMA includes the betterment of public health in this country and we need to do a better job emulating, supporting and advancing this important work.

The severity of the covid-19 pandemic clearly uncovered the deficits and deficiencies of the public health system in response to this crisis. The threat continues even as we meet for the AMA annual meeting. One of the important and pressing deficits in the US system is the lack of a strong cadre of medical leaders in the public health system. Preventive medicine specialties are the areas in medicine where physicians receive appropriate training in public health matters. Good medical leadership is critical for the foundation of the public health infrastructure. Residencies in preventive medicine specialties are disappearing due to necessary funding sources. The AMA as the voice of medicine in this country can sound the alarms now about this pressing need. In doing so, the AMA would be meeting its mission of the betterment of public health.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(JUN-21)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee C

1 Whereas, During the COVID-19 pandemic, physicians have been on the front lines, and have
2 experienced increased duress and extreme fatigue during the case surges as hospitals are
3 overrun with patients; and
4

5 Whereas, Longer shifts, disruptions to sleep and to work-life balance, and occupational hazards
6 associated with exposure to COVID-19 have contributed to physical and mental fatigue; and
7

8 Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and
9 excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as
10 shift work disorder;⁵ and
11

12 Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the
13 United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property
14 damage-only crashes;² and
15

16 Whereas, Physicians have a higher likelihood of dying from accidents than from other causes
17 relative to the general populations;⁴ and
18

19 Whereas, Physicians' risk of crashing while driving after working extended shifts (≥ 24 hours)
20 was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a
21 non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional
22 extended work shift hour;³ and
23

24 Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night
25 shift;⁶ and
26

27 Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for
28 physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a
29 blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;⁷
30 and
31

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

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further

RESOLVED, That the AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

COVID fatigue has been used to describe the intense and overwhelming fatigue, irritability and disorientation experienced by physicians and healthcare workers during the pandemic. The high patient volumes and extra shifts during surges place additional physiologic strain on physicians. It is important for that the AMA advocate for policies that support fatigue mitigation programs and make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being.

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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 motor 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: 314
(JUN-21)

Introduced by: Medical Student Section

Subject: Standard Procedure for Accommodations in USMLE and NBME Exams

Referred to: Reference Committee C

1 Whereas, The Americans with Disabilities Act (ADA) section 36.309 requires that any
2 documentation requested by a testing entity in order to evaluate a request for testing
3 accommodations be both reasonable and limited to only the information needed to determine
4 the nature of a candidate's disability and their need for the requested testing accommodations¹;
5 and
6

7 Whereas, Under ADA section 36.309, examples of legally-appropriate accommodation request
8 documents include: (1) recommendations by qualified healthcare professionals, (2) proof of past
9 testing accommodations, (3) observations by educators, (4) results of psycho-educational or
10 other professional evaluations, (5) an applicant's history of diagnosis, and (6) an applicant's
11 statement of his or her history regarding testing accommodations¹; and
12

13 Whereas, Under ADA section 36.309, depending on the nature of either the disability, or the
14 form of requested accommodation, a testing entity might only need one or two forms of
15 documentation to verify the nature of the candidate's disability and his or her need for the
16 requested accommodation¹; and
17

18 Whereas, Under ADA section 36.309, proof of past testing accommodations in similar test
19 settings is generally sufficient to support a request for the same testing accommodations for a
20 subsequent standardized exam or other high stakes test¹; and
21

22 Whereas, Under ADA section 36.309, if a candidate previously received testing
23 accommodations under an Individualized Education Program (IEP) or Section 504 Plan, they
24 should generally receive the same testing accommodations for a subsequent standardized
25 exam, with examples including extra time, additional or extended breaks, testing in a private
26 room, or other sight- or hearing-based accommodation^{1,2}; and
27

28 Whereas, Under ADA section 36.309, recognizing the importance of face-to-face evaluation for
29 a correct diagnosis, directs testing entities to give precedence to reports from qualified
30 professionals who have personally evaluated the candidate over reports from testing entity
31 reviewers who did not conduct an assessment of the candidate for diagnosis and treatment¹;
32 and
33

34 Whereas, The National Board of Medical Examiners (NBME) has a practice of reviewing and
35 sometimes denying accommodations requests without a face-to-face evaluation^{1,3}; and
36

37 Whereas, In *Berger v. the National Board of Medical Examiners*, the NBME denied an
38 accommodation request based on the testimony of NBME-paid outside experts who provided
39 their opinions without having evaluated the candidate^{1,3}; and

1 Whereas, This practice violates the ADA's requirement of deference to the opinions based on
2 in-person evaluations^{1,3}; and
3

4 Whereas, ADA section 36.309, states a qualified professional's decision not to provide results
5 from a specific test or evaluation instrument should not preclude approval of a request for
6 testing accommodations where the documentation provided by the candidate, in its entirety,
7 demonstrates that the candidate has a disability and needs a requested testing
8 accommodation¹; and
9

10 Whereas, According to ADA section 36.309, a testing entity must respond in a timely manner to
11 requests for testing accommodations, including when that entity requests additional information,
12 to ensure equal opportunity for applicants with disabilities to register and take the test in the
13 same testing cycle as their classmates as to not delay their medical education¹; and
14

15 Whereas, According to ADA section 36.309, failure by a testing entity to act in a timely manner,
16 coupled with requests for duplicative, unnecessary, or extraneous documentation, could result
17 in an extended delay such that it denies persons with disabilities equal opportunity or equal
18 treatment as their peers without disabilities¹; and
19

20 Whereas, American College Testing (ACT), which administered the ACT to approximately 1.91
21 million students in 2018, states that requests are normally processed in 10-14 business days^{4,5};
22 and
23

24 Whereas, The Law School Admission Council (LSAC), which administered the Law School
25 Admission Test (LSAT) to 138,597 students between June of 2018 and March of 2019, states
26 that students who request the same accommodations that they have received previously will
27 receive those accommodations without further documentation, as long as they provide
28 verification of that previous accommodation for a standardized test and the accommodation
29 does not require administration over multiple days^{6,7}; and
30

31 Whereas, The United States Medical Licensing Examination (USMLE) website states that the
32 applicant should wait 60 days for processing and requires a personal statement, complete and
33 comprehensive evaluation from a qualified professional done in the past three years, and
34 supporting documentation potentially including academic records, score transcripts for previous
35 standardized exams, verification of prior academic/test accommodations, relevant medical
36 records, previous psychoeducational evaluations, faculty or supervisor feedback, job
37 performance evaluations, and course evaluations^{2,8,9}; and
38

39 Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science
40 and Professional Education, a book which is written for health science administrators and
41 disability service providers, recommends beginning the accommodation request process 10
42 months before the planned exam date due to the rigor of completing the appropriate
43 documentation coupled with the time needed for processing and approval ²; and
44

45 Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science
46 and Professional Education states that the assessments students often need to qualify for
47 accommodations cost between \$1,200 to more than \$5,000 dollars depending on health
48 insurance and geographic location²; and
49

50 Whereas, A study by the Association of American Medical Colleges and the Human Resources
51 Research Organization found that medical students who received extended time on the Medical
52 College Admission Test (MCAT) had no difference in either MCAT scores or in rates of

admission to medical school, and even after they controlled for undergraduate GPA, the students who had received MCAT accommodations had between 8.1% to 18.9% lower graduation rates based on the number of years it took to graduate and an 11%, 9%, and 5% lower pass rate on Steps 1, 2 CK, and 2 CS respectively¹⁰; therefore be it

RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The issue of equitable access and disabilities is a priority for our delegation. This resolution touches on the heart of an issue not often considered for physicians: representation of all abilities. Both schools' technical requirements and the strict processes of NBME deter students with disabilities from becoming physicians. NBME requirements are even more stringent and difficult for students with temporary disabilities or new-onset disability, as it is difficult to prove "previous accommodations" on short notice given the timeline of requesting accommodations.

We believe that the asks of this resolution to standardize and improve the accommodations of medical students with disabilities to be salient. Although not officially recognized by the AAMC as underrepresented in medicine, persons with disabilities represent 0.3-2.7% of medical students and practicing physicians compared to 19.4% of US citizens. Medical students and physicians with disabilities provide high quality and culturally competent care to a diverse patient population, but are met by many barriers to practicing medicine. A standardized process to accommodations for licensing exams would be an appropriate step to addressing these barriers to practice.

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RELEVANT AMA POLICY**Accommodating Lactating Mothers Taking Medical Examinations H-295.861**

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. (Sub Res. 903, I-14; Modified Res. 310, A-17)

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. (CME Rep. 1, I-06, Reaffirmed: CME Rep. 7, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13, Modified: CME Rep. 01, A-16, Reaffirmation: A-16)

Advocacy for Physicians with Disabilities D-90.991

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

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

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

Enhancing Accommodations for People with Disabilities H-90.971

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

A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(JUN-21)

Introduced by: Medical Student Section

Subject: Representation of Dermatological Pathologies in Varying Skin Tones

Referred to: Reference Committee C

Whereas, Worse healthcare outcomes result from the under recognition of dermatologic pathologies, such as erythema migrans and the late detection of melanoma in individuals with darker skin tones – also known as Fitzpatrick skin types III-VI¹⁻⁴; and

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

Whereas, There is a lack of targeted skin cancer awareness and prevention efforts for patients with darker skin tones⁹ resulting in lower rates of skin cancer screening; and

Whereas, Research has demonstrated that patients with darker skin tones feel frustrated when dermatologists do not demonstrate competency recognizing and treating pathologies on darker skin¹⁰; and

Whereas, It has been shown that overrepresentation of minority group skin tones relative to their proportion in the population is required to achieve equitable diagnostic outcomes¹¹⁻¹³; and

Whereas, About 75 percent of dermatological imagery in medical textbooks represent individuals with lighter skin tones while core dermatology textbooks used to educate trainees, dermatologists, and generalists have limited representations of skin of color¹⁴; and

Whereas, Terms such as “Classic Presentation” are usually examples of lighter skin tones¹⁵; and

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

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

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

RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New HOD Policy); and be it further

1 RESOLVED, That our AMA encourage the development of educational materials for medical
2 students and physicians that contribute to the equitable representation of diverse skin tones (New
3 HOD Policy); and be it further
4

5 RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic
6 medical education materials. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation believes that this expands upon existing AMA priorities on race in medicine and medical education. Our colleagues have shared anecdotes on the paucity of pathologies presented on various skin tones, making the recognition of even "simple" skin diagnoses or clinical findings more challenging. That lack of exposure to presentations of various skin tones or awareness of their preconceived biases in this realm can further misdiagnoses or missed diagnoses. Dearth in knowledge of this increases risk for misdiagnosis in patients and shows another example of how disparities in healthcare occur.

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RELEVANT AMA POLICY

Early Detection and Prevention of Skin Cancer H-55.972

Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.
CCB/CLRPD Rep. 3, A-14

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

CME Rep. 11, A-06, Reaffirmation A-11, Modified in lieu of Res. 908, I-14, Reaffirmed in lieu of Res. 306, A-15, Reaffirmed: BOT Rep. 39, A-18, Modified: CME Rep. 01, A-20

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians

to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

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

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

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

CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19

Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963

Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers.

Sub. Res. 306, A-09, Reaffirmed: CME Rep. 01, A-19

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03, Appended: CME Rep. 6, A-11, Modified: CME Rep. 3, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: Reference Committee C

1 Whereas, The Americans with Disabilities Act (ADA) defines a disability as “a physical or mental
2 impairment that substantially limits one or more major life activities of an individual; a record of
3 such an impairment; or being regarded as having such an impairment”^{1,2}; and
4

5 Whereas, In enacting the Americans with Disabilities Act, “Congress recognized that physical
6 and mental disabilities in no way diminish a person’s right to fully participate in all aspects of
7 society, but that people with physical or mental disabilities are frequently precluded from doing
8 so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional
9 barriers”¹; and
10

11 Whereas, Research has found that concordances between patient and physician’s race and
12 ethnicity significantly enhanced the patient’s healthcare experience, compliance and outcomes,
13 yet little has been done to ensure the same for patients with disabilities^{3,4}; and
14

15 Whereas, Patients with disabilities feel their doctors who don’t have disabilities do not
16 understand the realities of their struggles, yet barriers persist in preventing people with
17 disabilities from entering the medical profession^{5,6}; and
18

19 Whereas, People with disabilities comprise about a quarter of the US adult population, but only
20 5 percent of medical students and 2 to 10 percent of practicing physicians⁶⁻¹⁰; and
21

22 Whereas, Medical school applicants and students may not be aware that they qualify for
23 protection based on the broader definition of disability in the ADA or may be discouraged from
24 disclosing an existing or newly arising disability due to fear of discrimination in admissions or
25 licensure¹¹⁻¹³; and
26

27 Whereas, Section 504 of the Rehabilitation Act states that, at the postsecondary level,
28 institutions are “required to provide students with appropriate academic adjustments and
29 auxiliary aids and services that are necessary to afford an individual with a disability an equal
30 opportunity to participate in a school’s program”¹⁴; and
31

32 Whereas, Accrediting bodies, including but not limited to the Liaison Committee on Medical
33 Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), have not
34 established a uniform list of essential abilities and technical standards or requirements for
35 reasonable accommodations in medical school or residency¹⁵⁻¹⁷; and
36

37 Whereas, This lack of standardized guidelines directly impacts a medical school’s
38 understanding of accommodations, assistive technology, acceptable use of intermediaries,
39 alternative learning experiences, and individualized assessment of disability under current law<sup>15-
40 17</sup>; and

1 Whereas, Studies have shown that as many as 49 percent of the medical schools did not clearly
2 state accommodation policies, many accommodation policies were difficult to locate, and some
3 schools provided no information whatsoever, making them non-compliant with Section 504 of
4 the Rehabilitation Act¹⁷⁻¹⁹; and

5
6 Whereas, A recent study showed that most medical school technical standards do not support
7 the provision of reasonable accommodations for students with disabilities as intended by the
8 ADA (e.g., proscribing intermediaries and auxiliary aids for hearing, vision, and mobility
9 disabilities)¹⁹; and

10
11 Whereas, Hearing loss is the most common physical and sensory disability encountered in
12 medical schools, with accommodations ranging from sign language interpreters to stethoscopes
13 that amplify heart and lung sounds, but closed captions, which provide full and equitable access
14 to video content to individuals with hearing loss, are not a standard option^{20,21}; and

15
16 Whereas, Closed captions translate spoken language into written language and provide helpful
17 clues to the person reading them by also identifying the person speaking, describing sound
18 effects, and giving other relevant information²²; and

19
20 Whereas, Closed captioning services are simple and inexpensive to implement through software
21 that supports real time voice-to-text transcription to automatically caption videos²³; and

22
23 Whereas, Although closed captions were originally designed to aid individuals who were deaf or
24 hard-of-hearing, a meta-analysis of over 100 studies has shown that captions benefit student
25 learners regardless of disability status by improving retention and comprehension (including
26 those who are watching videos in a non-native language)²²⁻²⁵; and

27
28 Whereas, Existing AMA policies support improving access and support for clinicians, learners,
29 and patients with disabilities (e.g., H-350.978, H-200.951, H-90.987, H-90.971, D-295.963); and

30
31 Whereas, Our AMA plays an existing role in developing policy and initiatives related to
32 improving undergraduate medical education, including but not limited to the Accelerating
33 Change in Medical Education Initiative, which has already begun to investigate meeting
34 disability-related needs²⁶; and

35
36 Whereas, Improving support and access for medical students and physicians with disabilities
37 can improve patient care, impact research agendas and workplace attitudes toward disability,
38 and reduce the significant barriers to health care, discrimination, and ableism experienced by
39 people with disabilities^{3,27-32}; therefore be it

1 RESOLVED, That our American Medical Association amend policy D-295.929 by addition to
2 read as follows:

3
4 D-295.929 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR
5 TRAINEES WITH DISABILITIES

6 Our AMA will work with relevant stakeholders to study available data on: (1) medical
7 trainees and students with disabilities and consider revision of technical standards for
8 medical education programs; and (2) medical graduates and students with disabilities
9 and challenges to employment after training and medical education; and 3) work with
10 relative stakeholders to encourage medical education institutions to make their policies
11 for inquiring about and obtaining accommodations related to disability transparent and
12 easily accessible through multiple avenues including, but not limited to, online platforms.
13 (Modify Current HOD Policy); and be it further
14

15 RESOLVED, That our AMA amend policy D-90.991 by addition and deletion to read as follows:

16
17 D-90.991 – ADVOCACY FOR PHYSICIANS WITH DISABILITIES

18 1. Our AMA will study and report back on eliminating stigmatization and enhancing
19 inclusion of physicians and medical students with disabilities including but not limited
20 to: (a) enhancing representation of physicians and medical students with disabilities
21 within the AMA, and (b) examining support groups, education, legal resources and any
22 other means to increase the inclusion of physicians and medical students with
23 disabilities in the AMA.

24 2. Our AMA will identify medical, professional and social rehabilitation, education,
25 vocational training and rehabilitation, aid, counseling, placement services and other
26 services which will enable physicians and medical students with disabilities to develop
27 their capabilities and skills to the maximum and will hasten the processes of their
28 social and professional integration or reintegration.

29 3. Our AMA supports physicians, and physicians-in-training, and medical
30 student education programs about legal rights related to accommodation and freedom
31 from discrimination for physicians, patients, and employees with disabilities. (Modify
32 Current HOD Policy); and be it further
33

34 RESOLVED, That our AMA collaborate with the Association of American Medical Colleges
35 (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other
36 relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical
37 school communications, including but not limited to lecture recordings, videos, webinars, and
38 audio recordings, that may prohibit any students from accessing information. (Directive to Take
39 Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Medical trainees with disability graduate medical school at a significantly lower rate than trainees without disability, despite meeting the medical school physical/intellectual requirements for admission. These trainees experience significant barriers to receiving accommodations, including lack of access to proper care and evaluation, lack of approval of accommodations, stigma of accommodations, and a need to spend precious study time self-advocating and learning the legal framework. Medical trainees with disability spend many hours a week managing disability and advocating from it, which detracts from their ability to spend time on medical school. In order to minimize the amount of time spent on advocating for accommodations and pushing for administration to respond, systemic access should be promoted to accommodate all individuals pursuing medical studies.

Medicine is not a field that is accommodative of individuals not in perfect health, despite being a field that tries to serve such populations. This has been shown time and time again when NBME has received litigation for violating Americans with Disabilities Act. In 2020, NBME had 2 lawsuits brought forth against it for ADA violations. In the light of the COVID pandemic, disability rights in education have been further infringed upon, making this resolution timely and in line with AMA priorities to promote health equity for all individuals, including medical trainees pursuing their careers as physicians.

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RELEVANT AMA POLICY

Discrimination B-14

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

Civil Rights & Medical Professionals 9.5.4

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

Issued: 2016

Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.

(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.

(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.

(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.

(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.

(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A_16; Reaffirmation: A-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
 5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
 6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
 7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
 8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
 9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
 10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
 11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
 12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
- CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

Equal Access for Physically Challenged Physicians H-90.987

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

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

Res. 220, I-17

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A_08; Reaffirmation: A-13; Reaffirmation: A-16

Creating an Effective Environment for Medical Student Education H-295.900

1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.
2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning.

The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated.

Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic

community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

Insurance Coverage for Medical Students and Resident Physicians H-295.942

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14

Due Process H-295.998

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and

written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others. CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

BOT Rep. 1, I-93; CME Rep. 10, I-94; Reaffirmed: CME Rep. 2, A_04; Reaffirmed: CME Rep. 2, A-14

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Res. 705, A-13

Remediation Programs for Physicians D-295.325

1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.
2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.
3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.

4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.

5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians.

CME Rep. 3, A-09; Reaffirmed: CME Rep. 01, A-19

Medical Staff Development Plans H-225.961

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.

BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation: A-10; Modified: CMS Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(JUN-21)

Introduced by: New Jersey

Subject: Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America

Referred to: Reference Committee D

Whereas, Excess adipose tissue, an active endocrine organ, more commonly referred to as obesity has been a key contributor to poor health and to the most common complications such as cardiovascular disease associated with higher risks of death during pregnancy; and

1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16

Whereas, The COVID-19 pandemic has further led the CDC to recognize obesity as the 2nd most significant risks factor for severe COVID infection and death from COVID -19; and ¹⁷

Whereas, The cost of care attributable to obesity has been estimated in 2016 at > 1.72 trillion dollars (9.3% of GDP per year) while the cost saving of weight loss has been measured and is substantial; and ^{25,26}

Whereas, Despite years of advocacy already undertaken by our AMA and other medical organizations, the prevalence of obesity has consistently increased, now affecting nearly 200 million lives in the US, and has contributed to killing an estimated 320,000 Americans per year; and ^{23,24}

Whereas, Effective evidence-based interventions such as intensive lifestyle modifications, pharmacotherapy, and surgery to prevent and treat obesity exist, and such interventions have been shown to be associated with improved health and pregnancy outcomes and reduced health care costs; and ^{6,27,28,29,30,31,32,33,34,35,36,37,38,39,40}

Whereas, Significant barriers to providing care to patients, particularly within minority communities where 54% of Black and 50% of Hispanic women in comparison to 38% of white women are affected by obesity remain; ^{23 24,41,42,43} and

Whereas, The 1933 White House Conference on Maternal Mortality and Child Health protection, which led to a call for action by state medical association and resulted in a 100-fold decrease in maternal mortality, is recognized as one of the greatest healthcare accomplishments of the 20th century and provides precedent; therefore be it ¹⁸

RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/10/21

AUTHOR'S STATEMENT OF PRIORITY

Statement of Urgency and Need for National Call for Action.

Obesity has long been recognized as a key contributor to poor health, as well as to the various medical and surgical complications associated with higher risk of Maternal Mortality and Morbidity.^{1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16}

Obesity was also recognized more recently by the CDC as 2nd only to age as a major risk factor for severe COVID infection and death.¹⁷

Despite all of its resources, the United States has the highest maternal mortality rate among developed countries, the disparity in rates for minority women are 4 - 5.2 times higher than for white and even higher in certain places.^{18,19,20,21,22,23,24}

The incomprehensible loss of lives during the COVID-19 pandemic has been exacerbated by the epidemic of obesity.¹⁷ Obesity related healthcare cost in 2016 was estimated at over 1.7 trillion dollars.²⁵ Cost savings from weight reduction are expected to be substantial.²⁶

Reducing obesity would have a significant impact on deaths from COVID-19 as well as on maternal mortality. With obesity prevalence historically highest among minority women now affecting > 50% of minority women the contribution of obesity to maternal mortality and morbidity and death from Covid-19 can no longer be ignored.^{17,18,23,24,25}

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(JUN-21)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Support for Safe and Equitable Access to Voting

Referred to: Reference Committee D

1 Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and
2 residents to vote by mail¹; and
3

4 Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot
5 by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept
6 risk or fear of COVID-19 infection as a valid reason²⁻⁴; and
7

8 Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January
9 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over
10 198,000⁵⁻⁶; and
11

12 Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking,
13 with a prevalence of 14% of adults in 2018⁷; obesity, with a prevalence of 42% of adults in
14 2017-2018⁸; and diabetes with a prevalence of 10% of adults in 2018⁹; and
15

16 Whereas, Public health experts continue to warn governments and the public to prepare for
17 future pandemics which may arise similarly to the COVID-19 pandemic¹⁰⁻¹²; and
18

19 Whereas, A study of the 2020 Wisconsin primaries found “a statistically and economically
20 significant association between in-person voting and the spread of COVID-19 two to three
21 weeks after the election”¹³; and
22

23 Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with
24 reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle
25 closures, limited in-person interactions, and the cancellation of many large public gatherings¹⁴;
26 and
27

28 Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to
29 fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and
30 longer waiting times in the 2020 primaries¹⁵⁻¹⁷; and
31

32 Whereas, Following widespread adoption of community mitigation measures to target SARS-
33 CoV-2, influenza rates among sentinel countries in the southern hemisphere have been
34 dramatically lower than historical averages during their peak influenza season¹⁸, suggesting the
35 continuance of such measures past the COVID-19 pandemic could contribute to a reduction in
36 the incidence of influenza; and
37

38 Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability¹⁹; and

1 Whereas, In the 2016 general election, the US Government Accountability Office found that
2 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in
3 unsafe or insecure conditions for these voters²⁰; and
4

5 Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse
6 absentee balloting and permanent absentee voting increases voter turnout among citizens with
7 disabilities²¹; and
8

9 Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure
10 that likely has increased in the years since given greater life expectancy among
11 immunosuppressed adults due to advancements in medical management and new indications
12 for immunosuppressive treatments²²; and
13

14 Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote
15 share²³; and
16

17 Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately
18 23.1% of all votes cast in the 2018 general election having been by mail²⁴; and
19

20 Whereas, Members of the military have voted-by-mail in some form since the Civil War, and
21 citizens living abroad also submit their ballots by mail²⁵⁻²⁷; and
22

23 Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately
24 increases overall average turnout rates, in line with previous estimates²³; and
25

26 Whereas, Numerous national and local government officials have expressed opposition to
27 expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection^{24,28-32}; and
28

29 Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one
30 study finding only 0.0025% of votes being flagged as possible cases of election fraud in the
31 2016 and 2018 general elections³³; and
32

33 Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel
34 the in-person proceedings of the 2020 Interim Meeting while preserving the voting process
35 through transition to an innovative virtual format³⁴; and
36

37 Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will
38 continue to be an urgent risk for voters and poll workers in subsequent elections like federal
39 runoff elections conducted in Georgia and Louisiana and local elections conducted in Spring
40 2021³⁵⁻³⁸; therefore be it
41

42 RESOLVED, That our American Medical Association support measures to facilitate safe and
43 equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate
44 unnecessary risk of infectious disease transmission by measures including but not limited to:

- 45 (a) extending polling hours;
- 46 (b) increasing the number of polling locations;
- 47 (c) extending early voting periods;
- 48 (d) mail-in ballot postage that is free or prepaid by the government;
- 49 (e) adequate resourcing of the United States Postal Service and election operational
- 50 procedures;
- 51 (f) improve access to drop off locations for mail-in or early ballots (New HOD Policy); and be
- 52 it further

- 1 RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to
2 receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New HOD
3 Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The AMA missed an opportunity to have a more significant voice during the last special election and continues to be left out of the important discussion regarding voting as a right and its contribution to the social determinants of health. Discussion of this resolution is timely for state and local election and if we will be prepared for 2022, we must pass this now to give our staff time to strategize. The asks are appropriately narrow, pertinent, and relevant to the large majority of our patients and colleagues.

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RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved

areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.

Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

H-65.971 Mental Illness and the Right to Vote

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

H-295.953 Medical Student, Resident and Fellow Legislative Awareness

1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.

2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.

3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.

4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Res. 14, A-91; Reaffirmed: Sunset Report, I-01; Appended: Res. 317, A-10; Appended: Res. 307, A-15

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

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

Res. 608, A-17

H-285.910 The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community.

Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment.

Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

Res. 8, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Traumatic Brain Injury and Access to Firearms

Referred to: Reference Committee D

1 Whereas, Traumatic brain injury (TBI) is a prevalent issue in society with approximately 1.7
2 million incidents annually, a third of which contribute to injury-related deaths in the US; and
3

4 Whereas, Although extensive research is conducted in the field to better assess interventions in
5 limiting consecutive brain damage after the initial head trauma, the actual mechanisms of neural
6 recovery are poorly understood; and
7

8 Whereas, An increased focus is placed on therapies to treat individuals who have sustained
9 brain injury and to improve their long-term recovery as many of these individuals suffer from
10 significant cognitive, behavioral, and communicative disabilities which interfere with their daily
11 activities and lives; and
12

13 Whereas, Approximately 20% of patients develop long-term medical complications such as
14 epilepsy, Alzheimer's disease, Parkinson's syndrome, and depression in addition to their initial
15 medical treatments after sustaining injury which costs the nation's healthcare more than \$56
16 billion each year; and
17

18 Whereas, There are some very important policies that the AMA has supported that relate to
19 gun violence and injury prevention. In H-145-997, the AMA acknowledges that firearms are a
20 public health problem, encourages research into innovative manufacturing techniques,
21 advocates for additional funding toward developing new safer weapon designs, and promotes
22 education programs for firearm safety and prevention; and
23

24 Whereas, Our AMA has since developed several other corollary policies surrounding firearm
25 violence prevention and intervention. Some of these policies asked for the establishment of
26 preventative measures which would target the sale and manufacture of guns, specifically to
27 decrease the availability. AMA policies calling for a waiting period preceding any firearm
28 purchase include H-145.991, H-145.992, and H-145.996. Policies calling for the imposition of
29 background checks for handgun purchases include H-145.991, H-145.996, H-145.970, and
30 H 145.972; and
31

32 Whereas, TBI is a wide-ranging diagnosis that encompasses a variety of phenotypes and
33 amending current policy would be more effective if intentionally defines TBI and high-risk
34 individuals; and
35

36 Whereas, Our AMA has policy supporting screening by physicians for a number of public
37 health and health concerns, including, not limited to: intimate partner and family violence
38 (D-515.980, H- 515.981), potential violent behavior within mental health assessments
39 (H-145.975), alcohol and drug use (H-30.942, H-95.922), pediatric mental health screening

(H-345.977), social and economic risk factors (H-160.896), maternal depression (D-420.991), and adverse childhood events (H-515.952); and

Whereas, While our AMA has policy regarding sports-related injuries and concussions, which includes TBI, there is not any policy that involves the importance of screening for active symptoms or history of TBI in settings such as primary care, pediatrics, psychiatry, neurology, schools, homeless shelters, within the criminal justice system, and athletic communities; and

Whereas, Failing to identify TBI may have severe consequences. Screening tools like the Ohio State University TBI-ID Method (OSU-TBI-ID), Brain Injury Screening Questionnaire (BISQ), HELPS Brain Injury Screening Tool, and Brain Check Survey may aid in the identification of those at risk for more severe consequences, and allow for supportive measures such as vocational rehabilitation or cognitive rehabilitation; therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-145.972 "Firearms and High-Risk Individuals" (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care" by addition and deletion to read as follows:

...2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental illness health and concurrent substance use disorders; in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.

~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

(Modify Current HOD Policy)

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

Received: 05/10/21

The topic of this resolution is currently under study by the Council on Science and Public Health.

AUTHOR'S STATEMENT OR PRIORITY

This policy will update current AMA policies to better address the burden traumatic brain injuries place on patients and ensure appropriate access to dangerous weapons.

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Screening and Brief Interventions For Alcohol Problems H-30.942

Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

Citation: CSA Rep. 14, I-99Reaffirmation I-01Modified: CSAPH Rep. 1, A-11Reaffirmation: A-18

Substance Use and Substance Use Disorders H-95.922

Our AMA:

(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18Reaffirmed: BOT Rep. 14, I-20

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

Citation: BOT Rep. 11, I-18

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18Reaffirmed: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Citation: Res. 414, A-11Appended: BOT Rep. 12, A-14Reaffirmed: Res. 403, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Citation: BOT Rep. 39, A-18Reaffirmed: CMS Rep. 10, A-19

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

- a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
- b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
- c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
- d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
- e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

Citation: Res. 504, A-19

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980

Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.

Citation: Res. 903, I-17Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: CSA Rep. I, A-92Reaffirmed: CSA Rep. 8, A-03Modified: CSAPH Rep. 1, A-13

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

Citation: Res. 910, I-17

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: Sub. Res. 34, I-89Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Modified: Res. 401, A-17Reaffirmation: A-18Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89Reaffirmed: BOT Rep.50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Reaffirmation: A-18

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmed: CSAPH Rep. 1, A-15Modified: BOT Rep. 12, A-16Appended: Res. 433, A-18Reaffirmation: I-18Modified: BOT Rep. 11, I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Citation: CSA Rep. A, I-87Reaffirmed: BOT Rep. I-93-50Appended: Res. 403, I-99Reaffirmation A-07Reaffirmation A-13Appended: Res. 921, I-13Reaffirmed: CSAPH Rep. 04, A-18Reaffirmation: A-18Reaffirmation: I-18Appended: Res. 405, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(JUN-21)

Introduced by: District of Columbia, American College of Cardiology, Obesity Medicine Association, American Association of Clinical Endocrinologists

Subject: Attacking Disparities in COVID-19 Underlying Health Conditions

Referred to: Reference Committee D

1 Whereas, COVID-19 mortality is much higher in individuals with obesity, diabetes, and
2 hypertension, compared with those who do not have these conditions; and
3

4 Whereas, These health conditions can be rapidly improved with appropriate medical treatment;
5 and
6

7 Whereas, The disproportionate impact of these chronic conditions in communities of color
8 contribute to disparities in COVID-19 mortality; and
9

10 Whereas, Medical treatment can be optimized when, as part of medical care, patients also
11 begin healthful lifestyle interventions, such as physical activity and reduced-sodium or plant-
12 based diets, which are already part of our AMA's policies for health care facilities (H-150.949),
13 public schools, food markets, restaurants (H-150.922), food assistance programs (H-150.944),
14 and federal health policy (D-440.978), but have been neglected during the Covid-19 pandemic,
15 causing overall health to decline and vulnerability to increase; and
16

17 Whereas, Existing AMA policy on obesity does not yet include the urgency, specificity, or call to
18 action required by the current pandemic and does not cover other underlying conditions; and
19

20 Whereas, While media attention has focused on reducing coronavirus transmission through
21 personal hygiene, masks, social distancing, and vaccinations, there has been insufficient
22 attention to the urgent need to control the underlying medical conditions that make COVID-19
23 especially deadly; therefore be it
24

25 RESOLVED, That our American Medical Association urge federal, state, and municipal leaders
26 to prominently note in their COVID-19 public health advisories the urgent need for individuals
27 with underlying medical conditions, particularly obesity, type 2 diabetes, and hypertension, to
28 consult with their physicians to assess their medical status and institute (or resume) appropriate
29 treatment, which may range from updating medications and lifestyle changes, such as reduced-
30 sodium and plant-based diets and physical activity, to aggressive medical therapy which may
31 include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

As of November 17, the final day of our interim meeting, 251,094 Americans had died from Covid-19. Between that date and April 20, 2021, Covid-19 killed an additional 304,868 Americans. Another 60,000 deaths are expected before August. While vaccines are essential for reducing mortality, the vaccination process is incomplete, and new viral variants make long-term vaccination efficacy uncertain. It is urgent that we protect our patients by addressing the underlying health conditions driving Covid-19 mortality. This resolution was introduced at the interim meeting but was deferred to the present meeting due to time constraints.

Covid-19 mortality is ten-fold higher when patients' diabetes is in poor control than when it is under good control. Similarly, poorly controlled hypertension increases Covid-19 mortality. With medical care, blood glucose and blood pressure control can be achieved within days. According to recent modeling, 30 percent of hospitalizations for COVID-19 are attributable to obesity, and although resolution of body weight is more challenging than blood pressure or blood sugar control, physicians play a vital role in this process.

Many patients have neglected their medical care during the pandemic and have allowed these chronic diseases to deteriorate. Local authorities are doing little to emphasize the urgency of controlling the underlying conditions that make Covid-19 a killer.

RELEVANT AMA POLICY

Healthful Food Options in Health Care Facilities H-150.949

1. Our AMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of Health Care Facilities.
2. Our AMA hereby calls on all Health Care Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for Health Care Facility cafeterias and inpatient meal menus to publish nutrition information.

Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18; Modified: Res. 904, I-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

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;

Reduction in Consumption of Processed Meats H-150.922

Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

Citation: Res. 406, A-19

Recognition of Obesity as a Disease H-440.842

Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Citation: (Res. 420, A-13)

Obesity as a Major Public Health Problem H-150.953

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

Citation: CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13;

Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18;

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

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980

Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.

Citation: Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(JUN-21)

Introduced by: Oregon

Subject: Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities

Referred to: Reference Committee D

1 Whereas, Maintaining appropriate staffing in healthcare facilities is essential to providing a safe
2 work environment for healthcare personnel (HCP) and safe patient care; and
3

4 Whereas, The Covid-19 pandemic has exposed gaps in our ability to safely staff long-term
5 healthcare facilities (LTC) due to rapid escalation in numbers of affected residents combined
6 with reduced numbers of staff available for their care; and
7

8 Whereas, Many complex factors contribute to reduced HCP availability in a pandemic situation
9 or other times of crisis including but not limited to: illness among healthcare personnel; social
10 factors such as transportation, housing, childcare and care of other family members;
11 widespread demand for HCP which creates a local deficit in staff availability and competition for
12 workers' scheduled time especially when HCP work at multiple facilities; quarantine
13 requirements for HCP who have had a suspected or known exposure; and
14

15 Whereas, The existing LTC workforce is disproportionately composed of racial and ethnic
16 minorities who are at risk for worse outcomes should they develop COVID-19 and they may also
17 be in high risk categories for other reasons or have family members in high risk categories,
18 reducing their willingness to assume the increased risk of caring for patients with highly
19 contagious illnesses; and
20

21 Whereas, The narrow revenue margin for companies managing LTC facilities dictates lean
22 staffing ratios in order to keep the business viable; and
23

24 Whereas, All these factors result in few options for mitigations of staffing challenges in LTC
25 facilities in a crisis, worsening the safety of HCP in the work environment and placing
26 residents/patients at risk of unsafe care environments when staff availability is reduced; and
27

28 Whereas, A safe and adequately resourced work environment is an issue of justice, equity,
29 and respect for both LTC workers and the vulnerable elderly population in our country;
30 therefore be it

1 RESOLVED, That our American Medical Association study the impact of SARS-CoV-2
 2 pandemic on post-acute care services and long-term care and residential facilities and
 3 collaborate with other stakeholders to develop policy to guide federal, state, and local public
 4 health authorities to ensure safe operation of these facilities during public health
 5 emergencies and natural disasters with policy recommendations to include but not limited to:

- 6
 7 a) Planning for adequate funding and access to resources;
 8 b) Planning for emergency staffing of health care and maintenance personnel;
 9 c) Planning for ensuring safe working conditions of LTC staff; and
 10 d) Planning for mitigation of the detrimental effects of increased isolation of residents during
 11 a natural disaster, other environmental emergency, or pandemic, or similar crisis.
 12 (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Oregon delegation considers this a Medium Priority Resolution. The SARS-CoV-2 (Covid-19) pandemic highlighted the exceptional healthcare provider (HCP) staffing challenges experienced in long-term care (LTC) facilities. Covid 19 has disproportionately impacted older adults and residents of long-term care facilities. Additionally, LTC facilities are also disproportionately composed of racial and ethnic minorities who are risk for worse outcomes should they develop Covid-19. In a pandemic such as Covid-19, current LTC staffing models, coupled with the greater impact Covid-19 has had on LTC residents, has left few options for mitigating staffing challenges. Additionally, HCP working in LTC facilities experience higher risk for contracting Covid-19, further jeopardizing staffing availability and increasing risk to residents/patients.

The American Medical Association (AMA) should study and collaborate to make policy to guide federal, state and local public health to ensure safe operation of LTC facilities during public health emergencies, including natural disasters. This resolution directly affects physicians who work in LTC facilities or closely with those facilities, but it also affects larger systems of care who may utilize providers from other locations to help mitigate staffing challenges during a public health emergency.

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html>
<https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm> (as of April 30, 2020)
<https://www.nytimes.com/2020/04/02/us/virus-kirkland-life-care-nursing-home.html>
<https://www.kff.org/medicaid/issue-brief/state-reporting-of-cases-and-deaths-due-to-covid-19-in-long-term-care-facilities/> (April 23, 2020)
<https://www.kff.org/medicaid/issue-brief/state-reporting-of-cases-and-deaths-due-to-covid-19-in-long-term-care-facilities/>
<https://www.kff.org/medicaid/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>
<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.w407>
<https://www.nytimes.com/2019/08/24/us/4-charged-hollywood-hills->

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(JUN-21)

Introduced by: Pennsylvania

Subject: Screening for HPV-Related Anal Cancer

Referred to: Reference Committee D

1 Whereas, 8,300 adults in the US will be diagnosed with anal cancer with an estimated 1,280
2 deaths in 2019¹; and

3
4 Whereas, The human papillomavirus (HPV) causes more than 90% of anal cancers² and HPV
5 testing can be conducted via screening anal Pap test and/or HPV test; and

6
7 Whereas, Studies have identified the value of anal cancer screening for high-risk populations
8 since AMA policy was adopted to support continued research on the diagnosis and treatment of
9 anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a
10 screening tool for anal cancer³; and

11
12 Whereas, The American Society for Colon and Rectal Surgeons (ASCRS) has developed a
13 strong recommendation based on moderate quality evidence, 1B, stating that patients at
14 increased risk for anal squamous neoplasms should be identified by history, physical
15 examination and laboratory testing, noting that the risk is higher in HIV-positive individuals, men
16 who have sex with men (MSM), and women with a history of cervical dysplasia⁴; and

17
18 Whereas, The American Cancer Society reports expert opinion that (1) anal pap smear testing
19 is a reasonable approach for screening patients at increased risk by swabbing the anal lining for
20 microscopic analysis; (2) although there is no widespread agreement on the best screening
21 schedule, some experts recommend the test be done every year in MSM or HIV-positive
22 individuals and every 2-3 years in the HIV-negative population; (3) patients with positive results
23 on an anal pap test should be referred for a biopsy; and (4) if anal intraepithelial neoplasia is
24 found on the biopsy, it might need to be treated especially if it is high grade⁵; and

25
26 Whereas, An expert panel convened by the American Society for Colposcopy and Cervical
27 Pathology and the International Anal Neoplasia Society suggests that HIV-positive women and
28 women with lower genital tract neoplasia may be considered for screening with anal cytology
29 and triage to treatment if anal high-grade squamous intraepithelial lesions (HSIL) is diagnosed⁶;
30 and

31
32 Whereas, Dacron swab cytology provides modest sensitivity and nylon-flocked swab cytology
33 has higher specificity and accuracy for detecting high grade squamous intraepithelial lesion in
34 anal cancer and has been proposed to lower costs of population-based screening⁷; and

Whereas, Preliminary analyses have shown anal cancer screening to be cost effective for HIV-positive individuals, MSM, and women with a history of cervical dysplasia with quality life adjusted years (QALYs) increases of 4.4 years at a cost of \$34,763 per life year gained overall, and particular cost effectiveness of annual anal pap testing for MSM at a cost of \$16,000 per QALY saved⁸; therefore be it

RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it further

RESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

National Cancer Institute. SEER anal cancer stat facts 2021 <https://seer.cancer.gov/statfacts/html/anus.html>.

Estimated New Cases in 2021 9,090

% of All New Cancer Cases 0.5%

Estimated Deaths in 2021 1,430

% of All Cancer Deaths 0.2%

The low prevalence of anal cancer in the general population prevents the use of routine screening. However, screening of selected populations has been shown to be a more promising strategy. Potential screening modalities include digital anorectal exam, anal Papanicolaou testing, human papilloma virus co-testing, and high-resolution anoscopy. Expands current policy to include up to date techniques.

Current AMA Policy

- Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
- Our AMA supports continued research on the diagnosis and treatment of **anal cancer** and its precursor lesions, including the evaluation of the **anal** pap smear as a **screening** tool for **anal cancer**.

References

1. Cancer Facts & Figures 2019
2. About HPV / HPV & Cancer. <https://www.analcancerfoundation.org/about-hpv/hpv-cancer/>
3. Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
4. Stewart, DB, et al. The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for Anal Squamous Cell Cancers: Dis of Colon & Rect. 2018 61(7): 755-774.
5. American Cancer Society Anal Screening: <https://www.cancer.org/cancer/anal-cancer/detection-diagnosis-staging.html>
6. Moscicki AB, et al. Screening for Anal Cancer in Women. Journal of Lower Genital Tract Disease. 2015 Jul; 19(3):S27-S42.
7. Wiley DJ, et al. Comparison of nylon-flocked swab and Dacron swab cytology for anal HSIL detection in transgender women and gay, bisexual, and other men who have sex with men. Cancer Cytopathol. 2019 Apr; 127(4):247-257.
8. Wells J, et al. An integrative review of guidelines for anal cancer screening in HIV-infected persons. AIDS Patient Care STDS. 2014 Jul;28(7):350-7.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(JUN-21)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Weapons in Correctional Healthcare Settings

Referred to: Reference Committee D

1 Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being
2 introduced into some Mental Health Units in federal correctional facilities in 2021; and

3
4 Whereas, Physicians in federal correctional healthcare settings who are employed by the
5 Federal Bureau of Prisons are considered law enforcement officers; and

6
7 Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State
8 Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for
9 Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks,
10 tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and

11
12 Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents
13 of serious workplace violence (requiring days off work) are four times more common in
14 healthcare settings than in private industry, so an intentional plan and response to reduce
15 workplace violence is indicated (OSHA, 2015); and

16
17 Whereas, The American Psychiatric Association does not support the use of weapons as a
18 clinical response in the management of patient behavioral dyscontrol in emergency room and
19 inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA,
20 2018); and

21
22 Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using
23 clinical approaches. These clinical approaches will typically involve psychological interpersonal
24 interventions and when less restrictive alternatives fail, the use of involuntary emergency
25 medication, physical seclusion, and physical or mechanical restraint, following guidelines issued
26 by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and

27
28 Whereas, The National Commission on Correctional Health Care supports the active prevention
29 of violence through nonphysical methods to prevent and/or control disruptive behaviors
30 including a balanced biopsychosocial approach (NCCHC, 2013); and

31
32 Whereas, Our *AMA Code of Ethics* notes "Physicians have civic duties, but medical ethics do
33 not require a physician to carry out civic duties that contradict fundamental principles of medical
34 ethics, such as the duty to avoid doing harm" (AMA Code of Ethics Opinion 9.7.2); and

35
36 Whereas, Our *AMA Code of Ethics* notes "Individual physicians who provide care under court
37 order should: Participate only if the procedure being mandated is therapeutically efficacious and
38 is therefore undoubtedly not a form of punishment or solely a mechanism of social control."

1 (AMA Code of Ethics Opinion 9.7.2); and

2
3 Whereas, Our *AMA Code of Ethics* notes “Preserving opportunity for physicians to act (or
4 to refrain from acting) in accordance with the dictates of conscience in their professional
5 practice is important for preserving the integrity of the medical profession as well as the
6 integrity of the individual physician, on which patients and the public rely” (AMA Code of
7 Ethics Opinion 1.1.7); and

8
9 Whereas, The presence of weapons from any source is likely to increase safety concerns
10 without added safety for patients or staff; and

11
12 Whereas, The presence of weapons within any healthcare facility may erode the physician-
13 patient relationship, limit access to care, and increase the vulnerability of those individuals and
14 communities who have experienced systemic racism and violence from law enforcement
15 officers (Liebschutz et al., 2010); and

16
17 Whereas, The presence of weapons within correctional healthcare facilities may trigger
18 aggression and agitation worsening behavioral dysregulation via the weapons effect (Berkowitz
19 and Le Page, 1967); therefore be it

20
21 RESOLVED, That our American Medical Association advocate that physicians not be required
22 to carry or use weapons in correctional facilities where they provide clinical care (Directive to
23 Take Action); and be it further

24
25 RESOLVED, That our AMA study and make recommendations regarding the presence of
26 weapons in correctional healthcare facilities. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

COVID-19 shone a bright light on the vulnerabilities with our healthcare systems and long-standing health disparities. Concurrently, the increased awareness of the police brutality experienced by Black individuals led the AMA to call racism a public health problem. Few areas of American life demonstrate the severity and urgency of both these public crises like the criminal justice system.

The U.S. has 5% of the world's population, yet 25% of the world's prisoners. Individuals within the criminal justice system have a higher burden of chronic physical/mental health disorders and a lower life expectancy. These individuals have a constitutional right to healthcare treatment. Yet, these facilities are underserved and under resourced.

Correctional facilities are the largest mental health institutions with 1 out of 5 individuals with serious mental health or substance use disorders. These people are more vulnerable and incarcerated longer than other prisoners. It is imperative that AMA's House of Delegates views issues related to healthcare treatment in these institutions as urgent business given the ongoing harms and the potential for even worse outcomes. AMA must advocate addressing the health safety of those designated to correctional facilities and their healthcare providers. This resolution asks AMA to provide care consistent with community treatment free of less lethal and lethal weapons in health care environments and second to advocate for physicians employed by federal correctional institutions to have maintain their individual right to decline to carry less lethal weapons in matter consistent with current policy where lethal weapons are not mandated.

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RELEVANT AMA POLICY

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977

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

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present

Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Policing Reform H-65.954

Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.

Citation: Res. 410, I-20

Mental Health Crisis Interventions H-345.972

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

Citation: Res. 923, I-15; Appended: Res. 220, I-18

Preventing Violent Acts Against Health Care Providers D-515.983

Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training.

Citation: Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, A-16;

Health Care While Incarcerated H-430.986

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

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

Referred to: Reference Committee D

Whereas, Due to the COVID-19 pandemic, 3 to 10 million Americans are likely to experience Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID"); and

Whereas, According to recent publications 10-30% of individuals who had COVID-19 reported at least one persistent symptom up to six months after their infection was cleared^{1,2}; and

Whereas, Individuals with PASC may experience varied and chronic symptoms including neurologic, cognitive, cardiopulmonary, constitutional, musculoskeletal, psychiatric, and mobility impairments; and

Whereas, Most patients impacted by PASC seek to regain their quality of life and return to being active members of their communities; and

Whereas, The current medical system in the United States lacks the necessary resources and infrastructure to adequately support and provide expert care to patients with PASC; and

Whereas, An application for an ICD-10-CM code for PASC has been submitted to the National Center for Health Statistics for review, but there is no current coding for PASC or organized reimbursement structure to support PASC multidisciplinary clinics nor are there dedicated resources to provide comprehensive care to PASC patients; and

Whereas, PASC patients need timely and local access to multidisciplinary care to address their complex needs including inequities inherent to our current health care system that result in disparate access associated with racial, ethnic, geographic, socioeconomic, and disability factors; and

Whereas, Ongoing and future PASC research results, that are inclusive of all populations, including people with disabilities and underlying health conditions, are needed in real-time to support providers through rapid development and widespread dissemination of best practices for PASC care; and

Whereas, Nearly 50 organizations including members of the federation have supported a letter urging the Biden Administration to launch a commission of diverse experts to develop a comprehensive federal crisis plan and prioritize actions to address the care needs of patients with PASC; therefore be it

¹ Rubin R. As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. JAMA. 2020; 324(14):1381–1383. doi:10.1001/jama.2020.17709

² Logue JK, et al "Sequelae in Adults at 6 Months After COVID-19 Infection" JAMA Netw Open 2021; DOI: 0.1001/jamanetworkopen.2021.0830.

1 RESOLVED, That our American Medical Association support the development of an ICD-10
2 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or
3 "Long COVID") as a distinct diagnosis (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA advocate for the development of immediate and long-term
6 strategies for funding and research to address equitable access to appropriate clinical care for
7 all individuals experiencing PASC (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA disseminate up-to-date information to physicians regarding best
10 practices to mitigate the effects of PASC in a timely manner. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered at the June 2021 Special Meeting of the AMA HOD, as it aims to address the current and future impact of COVID-19, including treatment of the ongoing symptoms following an initial COVID-19 infection. As we are still amid the pandemic, we have yet to fully realize the long-term effects of the virus. As 3 to 10 million Americans are likely to experience Long COVID, this issue will likely affect all physicians and their patients. Specifically, the goals of this resolution will ensure that patients who present with long COVID symptoms will have timely and local access to multidisciplinary care to address the broad and varying PASC symptoms. Time is of the essence for establishing a national strategy to address the Long COVID crisis. As the AMA and many other specialties have prioritized addressing the COVID-19 pandemic, having support from the full house of medicine will underscore this vital advocacy effort and will ensure PASC patients receive the care that is needed to reduce the long-term impacts of COVID-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(JUN-21)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont

Subject: Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the
Risk of Spread of Respiratory Pathogens

Referred to: Reference Committee D

Whereas, Respiratory pathogens are a known cause of significant yearly morbidity and mortality worldwide; and

Whereas, It has long been known that the wearing of a mask by those with respiratory infection can reduce the expulsion of infected droplets and reduce transmission of infection; and

Whereas, Recent studies in light of COVID-19 of wearing masks by people who are not infected have shown a reduction in the acquisition of the coronavirus;^{1,2,3,4} and

Whereas, The measures in place to reduce COVID-19, including use of masks by both the sick and the well, has been associated with unprecedented reductions in influenza and respiratory disease caused by other common viruses;⁵ and

Whereas, The risk of pathogens, which are transmitted via respiratory droplets or aerosols, is an ongoing concern for morbidity and mortality even after the pandemic;^{6,7,8} therefore be it

RESOLVED, That our American Medical Association endorse the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors (Directive to Take Action); and be it further

RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens. (Directive to Take Action)

¹ Nanda A, Hung I, Kwong A, et al. Efficacy of surgical masks or cloth masks in the prevention of viral transmission: Systematic review, meta-analysis, and proposal for future trial. *J Evid Based Med*. 2021. DOI: 10.1111/jebm.12424.

² Hemmer CJ, Hufert F, Siewert S, Reisinger E. Protection from COVID-19: The efficacy of face masks. *Dtsch Arztebl Int*. 2021;118(Forthcoming):arztebl.m2021.0119.

³ Coclite D, Napoletano A, Gianola S, et al. Face mask use in the community for reducing the spread of COVID-19: A systematic review. *Front Med (Lausanne)*. 2021;7:594269. DOI: 10.3389/fmed.2020.594269.

⁴ Freedman DO, Wilder-Smith AJ. In-flight transmission of SARS-CoV-2: A review of the attack rates and available data on the efficacy of face masks. *Travel Med*. 2020;27(8):taaa178.

⁵ Ibid.

⁶ Chu DK, Akl EA, Duda S, et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: A systematic review and meta-analysis. *Lancet*. 2020;395(10242):1973–1987.

⁷ MacIntyre CR, Chughtai AA. A rapid systematic review of the efficacy of face masks and respirators against coronaviruses and other respiratory transmissible viruses for the community, healthcare workers and sick patients. *Int J Nurs Stud*. 2020;108:103629. DOI: 10.1016/j.ijnurstu.2020.103629. Epub 2020 Apr 30.

⁸ Howard J, Huang A, Li Z, et al. An evidence review of face masks against COVID-19. *Proc Natl Acad Sci U S A*. 2021;118(4):e2014564118.

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

In spite of the fact there is an improvement in the spread of Covid, we face approximately 30,000 new cases daily in the US. Tragically worldwide there are extensive surges of Covid in South Asia and South America killing thousands daily.

The simplest evidence based public health measure to ameliorate the spread is to wear a mask. The AMA at the current meeting should endorse this resolution since there is currently extensive spread both domestically and internationally.

Just as important we should have this policy in place prior to the next flu season which will not happen if the resolution is delayed. Thank you in advance for your consideration of the urgency of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(JUN-21)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination and Support for Flexible Family Leave

Referred to: Reference Committee D

1 Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and
2 their experiences with workplace discrimination indicated that 77.9% of the respondents
3 experienced some form of discrimination;¹ and
4

5 Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender
6 discrimination and 35.8% reported experiencing maternal discrimination, which is defined as
7 self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;¹ and
8

9 Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the
10 Civil Rights Act of 1964, protects individuals from discrimination based on protected class such
11 as, sex, gender and pregnancy;² and
12

13 Whereas, The Fair Labor Standards Act includes some breastfeeding protections and
14 requirements for maternity leave but no protections for any additional leaves dealing with
15 parenting needs ;³ and
16

17 Whereas, The Families First Coronavirus Response Act (FFCRA or Act) provides employees of
18 covered employers two weeks of paid sick leave at the employee's regular rate or two-thirds the
19 employee's regular rate of pay and up to an additional ten weeks of paid expanded family and
20 medical leave at two-third of the employee's regular rate;⁵ and
21

22 Whereas, The FFCRA does not provide coverage protections for physicians and other frontline
23 workers as it specifically excludes health care providers and emergency responders;⁵ and
24

25 Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in
26 physicians experiencing maternal discrimination compared to 33.9% burnout in those not
27 experiencing maternal discrimination) even prior to the pandemic;¹ and
28

29 Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women
30 who are employed full time spend an additional 8.5 hours per week on childcare and other
31 domestic activities which was before the demands of virtual schooling and homeschooling;⁴ and
32

33 Whereas, Homeschooling rates have more than tripled during the pandemic due to educational
34 needs and health concerns;⁶ and
35

36 Whereas, Across the country almost two-thirds of parents say their children have switched to
37 online learning which requires adult supervision;⁷ and

Whereas, Mothers of young children have lost four to five times as many work hours compared to fathers in the pandemic due to women taking on the majority of childcare responsibilities;⁷ and

Whereas, Male physicians are increasingly expressing interest in flexible family leave and work options, yet female physicians continue to bear primary responsibility for caregiving and may face more challenges in aligning their career goals with family needs; and

Whereas, Conflicts between work and life responsibilities, which have been exacerbated due to the pandemic, can have adverse consequences for women physicians, leading to further discrimination; and

Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion of paid parental leave; calls for improved social and economic support for paid family leave to care for newborns, infants and young children; and advocates for federal tax incentives to support early child care and unpaid child care by extended family members; therefore be it

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (Directive to Take Action); and be it further

RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has had a regressive effect on gender equity, especially on women physicians who bear the burden of childcare in the household. The lack of services, such as education or childcare, has resulted in physicians with childcare responsibilities leaving the labor market. According to McKinsey Consulting, women's jobs are 1.8 times more vulnerable than men. Given the gender regressive pandemic scenario we are in, it is critical to take action now to advance gender parity. This resolution asks our AMA to urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare.

References:

- Adesoye T, Mangurian C, Choo EK, et al. Perceived Discrimination Experienced by Physician Mothers and Desired Workplace Changes: A Cross-sectional Survey. *JAMA Intern Med.* 2017;177(7):1033-1036.
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- Section 7(r), Fair Labor Standards Act - Break Time for Nursing Mothers Provision. Available at <https://www.dol.gov/agencies/whd/nursing-mothers/law>. Accessed 3/2/2020.
- Templeton K, Bernstein CA, Sukhera J, et al. Gender-Based Differences in Burnout: Issues Faced by Women Physicians. Available at <https://nam.edu/gender-based-differences-in-burnout-issues-faced-by-women-physicians/>. Accessed 3/10/2020.
- Families First Coronavirus Response Act: Employee Paid Leave Rights. Available at <https://www.dol.gov/agencies/whd/pandemic/ffcr-employee-paid-leave>
- Eggleston C, Fields J. Census Bureau's Household Pulse Survey Shows Significant Increase in Homeschooling Rates in Fall 2020. <https://www.census.gov/library/stories/2021/03/homeschooling-on-the-rise-during-covid-19-pandemic.html>

7. Henderson T. Mothers Are 3 Times More Likely Than Fathers to Have Lost Jobs in Pandemic. Pew Stateline Article. 9/28/2020. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/09/28/mothers-are-3-times-more-likely-than-fathers-to-have-lost-jobs-in-pandemic>

RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board

eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

Support of Human Rights and Freedom H-65.965

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

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

9.5.5 Gender Discrimination in Medicine

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

(a) Promote fairness in the workplace, including providing for:

(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;

(ii) on-site child care services for dependent children;

(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.

(b) Promote fairness in academic medical settings by:

(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;

(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;

(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;

(iv) structuring the mentoring process through a fair and visible system.

(c) Take steps to mitigate gender bias in research and publication.

AMA Principles of Medical Ethics: II,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to

establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee D

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

Whereas, The Institute of Medicine (IOM) developed diagnostic criteria for ME/CFS which require profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, orthostatic intolerance, and other symptoms³; and

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

Whereas, ME/CFS can be significantly disabling, leading to challenges with school, work, and activities of daily living¹; and

Whereas, ME/CFS can leave up to 25% of patients house- or bed-bound, sometimes for years¹; and

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

Whereas, Fewer than one-third of medical school curricula include information about ME/CFS, leading to a dearth of knowledge about how to diagnose and treat it³; and

Whereas, A Center for Disease Control study found that a significant portion of health care providers doubted or had misconceptions about the illness; for instance, a different study further found that 85% of providers thought the illness was wholly or partially psychiatric³; and

Whereas, 70% of physicians who had diagnosed a patient with ME/CFS felt the illness was more difficult to diagnose than other illnesses³; and

Whereas, An Institute of Medicine report estimates that between 836,000 and 2.5 million Americans suffer from ME/CFS, 90% of whom have not been diagnosed⁷; and

Whereas, The same report found that ME/CFS costs the U.S. economy between \$17 to \$24 billion annually in medical bills and lost incomes⁷; and

Whereas, A study of Severe Acute Respiratory Syndrome (SARS) survivors unable to return to work due to lingering effects reported that their symptoms closely mirrored those seen in ME/CFS³; and

Whereas, A comprehensive study of SARS survivors found that 27.1% met the modified 1994 Centers for Disease Control and Prevention criteria for Chronic Fatigue Syndrome four years after infection⁹; and

Whereas, SARS is a coronavirus with a higher fatality rate than the Coronavirus Disease 2019 (COVID-19) but has similar clinical features¹⁰; and

Whereas, As of September 20, 2020, the spread of the COVID-19 has led to a global pandemic, with nearly 6.8 million infections and almost 200,000 deaths in the United States alone¹¹; and

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

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

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face. (Directive to Take Action)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The term post-viral syndrome includes Myalgic Encephalomyelitis and Chronic Fatigue Syndrome (ME/CFS) and describes a constellation of symptoms that persist after a viral infection including profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, and orthostatic intolerance. The effects of ME/CFS can be significantly disabling and interfere with a patient's ability to work and perform activities of daily living.

Despite their debilitating effects, ME/CFS are not widely included in medical school curricula and many physicians possess only a limited understanding of them. In the current COVID-19 pandemic, the long-term effects of the virus are still unknown but a portion of patients have experienced prolonged symptoms that are similar to ME/CFS. Our delegation believes that further research and education regarding ME/CFS would be beneficial in recognizing these syndromes and reducing their harmful effects, especially given the size of the population affected by the COVID-19.

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RELEVANT AMA POLICY**Enhanced Zika Virus Public Health Action - Now D-440.930**

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

Res. 424, A-16

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

Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research. Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Viability of Clinical Research Coverages and Reimbursement H-460.965

Our AMA believes that:

- (1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
- (2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
- (3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
- (4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
- (5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
- (6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
- (7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
- (8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

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

(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and

(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.

CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep. 40, I-93;

Reaffirmed: CSA Rep. 13, I-99; Reaffirmation: A-00; Reaffirmed: CMS Rep. 4, A-02;

Reaffirmed: CMS Rep. 4, A-12; BOT Action in response to referred for decision: Res. 813, I-15;

BOT Action in response to referred for decision: Res. 823, I-15; Reaffirmation: I-18

Support of Biomedical Research H-460.998

Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal:

(1) The support of biomedical research is the responsibility of both government and private resources.

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

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

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

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

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

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

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

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

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

BOT Rep. S, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CSA Rep. 13, Sunset Report and Reaffirmation, A-00; Reaffirmation I-08; Reaffirmed: BOT action in response to referred for decision: Res. 526, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(JUN-21)

Introduced by: Medical Student Section

Subject: Call for Improved Personal Protective Equipment (PPE) Design and Fitting

Referred to: Reference Committee D

1 Whereas, The National Institute for Occupational Safety & Health (NIOSH) defines personal
2 protective equipment (PPE) as “equipment worn to minimize exposure to hazards that cause
3 serious workplace injuries and illnesses¹,” and
4

5 Whereas, The NIOSH definition includes items such as gloves, masks, safety glasses and
6 shoes, earplugs or muffs, hard hats, respirators, coveralls, vests and bodysuits¹; and
7

8 Whereas, Currently, “unisex” PPE is designed for European males and does not adequately
9 reflect the diversity in body types²⁻⁶; and
10

11 Whereas, Minorities, especially east Asian racial groups, and women, are more likely to struggle
12 to find PPE that fits appropriately²⁻¹⁰; and
13

14 Whereas, A 2016 Trade Union Congress survey found that only 29% of women used PPE that
15 was specifically designed for women and that 57% of women reported that improperly fitted
16 PPE sometimes or significantly hampered their work^{3,4}; and
17

18 Whereas, Improperly-fitted PPE puts users at risk for injuries, including tripping from too large
19 shoes, losing grip on items because of gloves that don’t fit, or in some settings, can lead to back
20 pain or foot injuries;³⁻⁶ and
21

22 Whereas, During the COVID-19 pandemic, studies have reported healthcare providers
23 developing pressure ulcers from attempting to form a seal with their masks^{11,12}; and
24

25 Whereas, Improperly-fitted PPE can cause their users added psychological stress due to safety
26 concerns while working^{13,14}; and
27

28 Whereas, At least some health-care professionals were diagnosed with COVID-19 and were
29 found to have improperly fitted masks¹⁵⁻¹⁸; and
30

31 Whereas, Properly fitting masks reduce healthcare professionals’ risk of contracting COVID-
32 19¹⁵; and
33

34 Whereas, A study of healthcare workers involved in aerosol-generating procedures found that
35 women had an increased hazard ratio of contracting COVID-19 of 1.36 after controlling for
36 confounding factors^{17,18}; therefore be it

- 1 RESOLVED, That our American Medical Association encourage the diversification of personal
- 2 protective equipment design to better fit all body types among healthcare workers. (Directive to
- 3 Take Action)

Fiscal Note: NOT YET DETERMINED

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the availability of PPE for our physicians and care teams since the beginning of this pandemic. However, despite the multitude of policies addressing the importance of clinician PPE (H-440.856, H-295.939, Code of Medical Ethics 8.4), none focus on the importance of well-fitted PPE that differentially fits diverse body types to ensure that all bodies are protected.

There is presently a lack of diversification in the PPE available to protect individuals from certain hazards that can lead to serious injuries and illnesses. Although the PPE is claimed to be "unisex", it has actually been reported to be designed to fit the face and body shape of "a default European male". This leaves a significant portion of individuals in vulnerable positions and we feel that there is an ethical responsibility to work to mitigate this problem. This resolution calls to encourage the development of a broader range of protective equipment, including PPE specifically designed for women's and minorities' bodies. By providing better fitting PPE, we can protect and preserve critically important healthcare workers on the frontlines of the coronavirus pandemic.

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RELEVANT AMA POLICY

Protecting Medical Trainees from Hazardous Exposure H-295.939

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.
2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.

Sub. Res. 229, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME/CSAPH Joint Rep. 01, A-19

8.4 Ethical Use of Quarantine and Isolation

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

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

- (a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
- (b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
- (c) Encourage patients to adhere voluntarily to quarantine and isolation.

- (d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
- (e) Inform patients about and comply with mandatory public health reporting requirements.
- (f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
- (g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.

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

- (h) Ensure that quarantine measures are ethically and scientifically sound:
 - (i) use the least restrictive means available to control disease in the community while protecting individual rights;
 - (ii) without bias against any class or category of patients.
- (i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
- (j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
- (k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
- (l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee D

Whereas, At the start of the COVID-19 pandemic in March 2020, U.S. hospitals faced critical shortages of essential medical supplies such as personal protective equipment (PPE), testing materials, and ventilators necessary for healthcare management and medical staff safety¹; and

Whereas, A study found that healthcare workers who were either reusing PPE or had inadequate PPE saw increased hazard ratios of contracting COVID-19 of 1.46 and 1.31 respectively²; and

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

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

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

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

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

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

Whereas, On April 1, 2020, only a few weeks after the World Health Organization declared a pandemic, the SNS was nearly out of all PPE supplies because it was not restocked after the swine flu pandemic in 2009 and left over supplies had expired⁵⁻¹¹; and

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

1 Whereas, On April 1, 2020, 1.5 million expired N95 masks were distributed to the Transportation
2 Security Administration and Customs Enforcement personnel, however, there are no programs
3 to assess and extend the shelf-life of PPE^{7,11}; and
4

5 Whereas, SNS supplies were distributed both inefficiently and to the wrong locations due to
6 allocations based upon outdated projections¹⁴; and
7

8 Whereas, Alternatives to current PPE distribution methods like computing-based healthcare
9 databases allow for PPE distribution in real time, lowering the cost and increasing distribution
10 effectiveness^{15,16}; and
11

12 Whereas, The AMA has twice called for the White House Coronavirus Task Force to incentivize
13 the manufacturing and distribution of PPE^{17,18}; and
14

15 Whereas, On June 26, 2020, in a letter to the Senate Committee on Health, Education, Labor,
16 and Pensions, the AMA highlighted the importance of “creating better coordination across
17 federal and state governments and streamlining pandemic response logistics” and “enhancing
18 state and federal stockpiles and improving the system for acquisition and distribution of
19 medically necessary supplies¹⁹,” therefore be it

1 RESOLVED, That our American Medical Association amend policy H-440.847 by addition and
2 deletion to read as follows:

3
4 Pandemic Preparedness for Influenza H-440.847

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

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

12 (2) urges Congress and the Administration to work to ensure adequate funding and
13 other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic
14 National Stockpile and other appropriate federal agencies, to support the maintenance
15 of and the implementation of an expanded capacity to produce the necessary
16 vaccines, and anti-viral microbial drugs, medical supplies, and personal protective
17 equipment, and to continue development of the nation's capacity to rapidly
18 manufacture the necessary supplies needed to protect, treat, test and vaccinate the
19 entire population and care for large numbers of seriously ill people; and (b) to bolster
20 the infrastructure and capacity of state and local health departments to effectively
21 prepare for and respond to, and protect the population from illness and death in an
22 influenza a pandemic or other serious public health emergency;

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

26 (4) urges the federal government to meet treaty and trust obligations by adequately
27 sourcing medical and personal protective equipment directly to tribal communities and
28 the Indian Health Service for effective preparedness and to respond to a pandemic or
29 other major public emergency;

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

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

41 (Z) will monitor progress in developing a contingency plan that addresses future
42 influenza-vaccine production or distribution problems and in developing a plan to
43 respond to an influenza pandemic in the United States. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to make substantive amendments to current AMA policy that better aligns with our current advocacy efforts. While our AMA has been a relentless force in advocating for our nation to maintain a stockpile of PPE and infrastructure to better prepare for future pandemics, currently AMA policy is restricted to influenza. This resolution proposes unique ways to amend Policy D-440.847 to address these issues by its language beyond the scope of an influenza pandemic, and adding specific language to encourage the development of the strategic national stockpile.

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RELEVANT AMA POLICY**Pandemic Preparedness for Influenza H-440.847**

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

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

CSAPH Rep. 5, I-12; Reaffirmation, A-15

AMA Role in Addressing Epidemics and Pandemics H-440.835

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially

infected with Ebola, and widely disseminate such guidelines through its communication channels.

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

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

Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

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

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

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

- (a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
- (b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
- (c) Encourage patients to adhere voluntarily to quarantine and isolation.
- (d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
- (e) Inform patients about and comply with mandatory public health reporting requirements.
- (f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
- (g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.

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

- (h) Ensure that quarantine measures are ethically and scientifically sound:
 - 1. Use the least restrictive means available to control disease in the community while protecting individual rights
 - 2. Without bias against any class or category of patients
- (i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
- (j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
- (k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
- (l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(JUN-21)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;¹ and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;^{2,3} and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;⁴ and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;⁵ and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;⁵⁻⁷ and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;³ and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency⁸; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;⁹ and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;⁹ and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics. Among millennials surveyed in 2015, only 12 percent said their sex education classes covered same-sex relationships;^{9,10} and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);¹¹ and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;³ and

Whereas, in 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;¹² and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;^{2,13} and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;¹⁴ and

Whereas, Since 2000, estimated medical costs of \$6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;¹⁵ and

Whereas, 40 states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;¹¹ and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;^{16,17} and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;¹⁸ and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;¹⁹⁻²¹ and

Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births²²; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;²³⁻²⁵ and

Whereas, Comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;^{23,26-28} and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including PREP, a state-grant program from the federal government that funds comprehensive sex education;^{29,30} and

Whereas, As of 2017, forty-one PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;²⁹ and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;³⁰ and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;³¹⁻³³ and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend policy H-170.968 by addition and deletion to read as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally s~~ Supports the concept of a ~~complementary~~ family life and sexuality

education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms, dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about including~~ contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
- (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
- (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
- (10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
- (Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Sexual health education has been an important but often neglected topic in the United States. Research indicates that sexual health education is of paramount importance to the wellness and health of adolescents and teens. The current abstinence only until marriage (AOUM) sex education is outdated and does not provide proper support and education to our youths. Medically accurate and comprehensive sexual health education will more than likely decrease the rate of STIs transmission and accidental pregnancies, among many other benefits. The LGBTQ+ community could benefit tremendously from improved training on sexual health education due to increased awareness of complications of unsafe sexual practices as well as promote tolerance towards the community.

This resolution lends much needed focus on utilizing the primary school setting as the principle method of providing medically accurate and comprehensive sexual health education, and does so through a benign amendment to HOD policy.

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RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e)

utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified: Res. 441, A-03;

Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16;

Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994

The AMA urges television broadcasters, producers, and sponsors to encourage **education** about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rp. 8, A-05; Reaffirmed:

CSAPH Rep. 1, A-15

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

- (2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
 - (3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
 - (4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
 - (5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
 - (6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
 - (7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
 - (8) Information on health and health care should be presented in an accurate and objective manner.
 - (9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
 - (10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
 - (11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
 - (12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
 - (13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
- BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation: A-07; Reaffirmation: A-15; Reaffirmed: BOT Rep. 15, A-19
Comprehensive Health Education H-170.977

(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach

the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.

BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation: A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
- b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(JUN-21)

Introduced by: Medical Student Section

Subject: Amendment to Food Environments and Challenges Accessing Healthy Food,
H-150.925

Referred to: Reference Committee D

Whereas, Having limited access to healthy and affordable food is recognized as a social determinant of health and disproportionately affects people in particular socioeconomic, racial, and ethnic groups, contributing to existing health disparities¹; and

Whereas, According to the 2020 United States Department of Agriculture Economic Research Service, 35% of low-income households struggle with food security according to 2018 data²; and

Whereas, More than 13 million US children lived in food-insecure households, which are described as homes where they lacked access to sufficient food to support a healthy and active lifestyle, and rates of food insecurity are twice as high among Black and Hispanic households compared to White households³⁻⁴; and

Whereas, Food insecurity across a child's first 5 years of life is associated with poorer outcomes on a range of family well-being indicators, lower levels of mental health, and higher levels of family conflict³; and

Whereas, Food insecurity showed that adults aged 20-39 had higher odds of having prediabetes/diabetes due to greater consumption of carbohydrates and less protein, a pattern that is linked to Types DM progression⁵; and

Whereas, The American Academy of Pediatrics and the American Academy of Family Physicians recognizes food insecurity as a major social determinant of health and advocates for federal and local policies that support access to adequate healthy food⁶⁻⁷; and

Whereas, A food desert is defined as an area that lacks access to affordable and healthy food and is typically used to describe low-income rural and urban neighborhoods that either do not have a nearby grocery store or where a large portion of residents are unable to travel to or afford the existing healthy food⁸; and

Whereas, A food swamp is defined as an area with abundant access to unhealthy foods and fast food restaurants and limited access to healthy foods and grocery stores⁹; and

Whereas, A food mirage is defined as an area where grocery stores exist but their prices make them inaccessible to low-income families¹⁰; and

1 Whereas, The lack of access to healthy foods and increased prevalence of low price stores that
2 promote junk foods are important factors in obesity and chronic disease among individuals in a
3 food desert¹¹; and
4

5 Whereas, According to The Food Trust “A study of nearly 4,000 adults living in New Orleans
6 found that each additional supermarket in a participant’s neighborhood is associated with
7 reduced risk for obesity, while fast-food and convenience store access are predictive of greater
8 odds of obesity”¹²; and
9

10 Whereas, An estimated 13.5 million people in the United States have low access to a
11 supermarket or large grocery stores, with 82% of these individuals living in urban areas⁸; and
12

13 Whereas, 23.5 million people live in low-income areas that are more than 1 mile from a
14 supermarket, which represents 8.4% of the US population⁸; and
15

16 Whereas, In any given year, 13% of households are car-less and 45% of families in poverty do
17 not own a car¹³⁻¹⁴; and
18

19 Whereas, Many low-income households cannot afford the cost of traveling to a supermarket
20 outside their neighborhood¹⁵⁻¹⁶; and
21

22 Whereas, Minority communities are frequently found to have decreased availability of
23 supermarkets, grocery stores, and affordable healthy foods and increased prevalence of
24 convenience stores and fast food restaurants¹⁷⁻¹⁹; and
25

26 Whereas, The defining characteristic of communities with limited food access are higher levels
27 of racial segregation and income inequality in urban areas and lack of transportation
28 infrastructure in rural areas²⁰; and
29

30 Whereas, According to the Robert Wood Johnson Food Foundation, the federally funded
31 community-based Healthy Food Financing Initiative (HFFI) supported Mandela Partners’
32 distribution of “650,000 pounds of fresh produce, 46% of which comes from small family farms
33 within 200 miles of Oakland, helping keep farmers on the land and increasing their income by
34 over \$300,000”, and “increasing access to nutritious food in low-income communities and
35 communities of color”²¹⁻²³; and
36

37 Whereas, Implementation of the community-based Healthy Navajo Stores Initiative to increase
38 produce availability in a food desert and the Navajo Fruit and Vegetable Prescription Program (a
39 food voucher program) resulted in a significant increase in the likelihood of individuals
40 purchasing produce, especially at independently owned stores, and in one study cohort,
41 participating families increased their produce consumption by 48% and child BMI decreased by
42 41%²⁴⁻²⁵; and
43

44 Whereas, Non-profit and community-driven supermarket interventions in food deserts have
45 been shown to be more likely to remain open long-term compared to government-driven or
46 commercial-driven models, suggesting that community engagement is a necessary component
47 of sustainable food access interventions²⁶; and

Whereas, Current AMA policy (D-150.978) expresses the need for healthcare to support and model ecologically sustainable food systems and “encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation”; and

Whereas, Current AMA policy (H-150.925) only encourages the study of problems concerning “food mirages, food swamps, and food oases as food environments distinct from food deserts”, there is no policy highlighting the importance of food access on health and health inequality; therefore be it

RESOLVED, That our American Medical Association amend policy H-150.925, “Food Environments and Challenges Accessing Healthy Food,” by addition and deletion as follows,

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR’S STATEMENT OF PRIORITY

Our delegation priorities protections and health of marginalized or vulnerable populations, including access to nutritious foods. This resolution asks the AMA to amend H-150.925 to recognize that food access inequities disproportionately impact marginalized communities and that community-level initiatives, versus federally-based programs, pose a sustainable solution to these challenges.

Healthy food access is a critical component of healthy societies. Inequitable access to nutritious food, especially during this pandemic, has increased the utilization of food banks in marginalized communities and underscores the need for healthy, resilient food infrastructure. While existing AMA policy supports healthy food initiatives, the intersectionality between food access and socioeconomic or racial status has not been previously defined. Our delegation believes this resolution will strengthen our AMA policy beyond studying the well-researched national prevalence, impact, and solutions of food access to include an acknowledgment of the effects of food access inequality on marginalized communities and people of color and the need to empower and support these communities.

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RELEVANT AMA POLICY

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.

Res. 921, I-18

Sustainable Food D-150.978

“Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

CSAPH Rep. 8, A-09; Reaffirmed in lieu of: Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of: Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res. 414, A-10; Reaffirmation: A-12; Reaffirmation: A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation: A-14; Reaffirmation: I-14; Reaffirmation: A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(JUN-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee D

Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior¹; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual²; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately²; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic³; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM⁴; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women⁵⁻⁶; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention⁵⁻⁶; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population³; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos⁷; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily⁸⁻⁹; and

1 Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million
2 additional individuals would benefit from being on it¹⁰⁻¹³; and

3
4 Whereas, 69% of the individuals that could benefit from PrEP are Black or Hispanic, yet these
5 individuals comprise only 4% of the individuals that are prescribed it¹¹⁻¹²; and

6
7 Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the
8 United States, as people of color and women bear a high HIV burden, but have a
9 disproportionately limited uptake¹⁴; and

10
11 Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the
12 most frequently cited barrier to prescribing it being lack of knowledge¹⁵⁻¹⁶; and

13
14 Whereas, A 2018 study showed that medical students were unable to identify individuals at
15 highest risk of HIV acquisition and recommend PrEP accordingly¹⁷; and

16
17 Whereas, Educational interventions targeted at primary care physicians that focus on HIV
18 epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to
19 prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to
20 increase rates of PrEP prescribing when clinically indicated¹⁶; and

21
22 Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office
23 visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality,
24 contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as
25 early as age 11¹⁸⁻¹⁹; and

26
27 Whereas, It is considered a best practice in primary care settings to educate patients about all
28 the available options for preventing STIs, especially in sexually active adolescents and in adults
29 at increased risk for STIs¹⁸⁻¹⁹; and

30
31 Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative
32 individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients^{8,15}; and

33
34 Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-
35 white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP
36 uptake, was suggestion to initiate PrEP by a healthcare provider¹⁴; and

37
38 Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-
39 350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and
40 ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective
41 medical diagnosis and treatment"; and

42
43 Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the
44 consistency and equity of care for all persons" and "supports research to identify the most
45 effective strategies for educating physicians on how to eliminate disparities in health outcomes
46 in all at-risk populations"; and

47
48 Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV
49 prevention and treatment nor proposes a specific intervention to reduce such disparities;
50 therefore be it

1 RESOLVED, That our American Medical Association amend AMA Policy H-20.895 "Pre-
2 Exposure Prophylaxis (PrEP) for HIV," by addition to read as follows:

3
4 Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

- 5 1. Our AMA will educate physicians, physicians-in-training, and the public about the
- 6 effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical
- 7 Practice Guidelines.
- 8 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
- 9 3. Our AMA supports the removal of insurance barriers for PrEP such as prior
- 10 authorization, mandatory consultation with an infectious disease specialist and
- 11 other barriers that are not clinically relevant.
- 12 4. Our AMA advocates that individuals not be denied any insurance on the basis of
- 13 PrEP use.
- 14 5. Our AMA encourages the discussion of and education about PrEP during routine
- 15 sexual health counseling, regardless of a patient's current reported sexual
- 16 behaviors. (Modify Current HOD Policy)
- 17

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to reduce existing disparities through universal PrEP counseling. Our delegations believe that this resolution will add significant value to LGBTQ+ health. Universal PrEP counseling also addresses the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people of color as well as low-income LGBTQ individuals. Finally and most importantly, this resolution emphasizes patient-centered care: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

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

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
- Reaffirmed: CSAPH Rep. 01, I-18

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.

Modified: Res. 16, A-18

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

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

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
- Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

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

Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(JUN-21)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee D

1 Whereas, School-related arrests and juvenile justice referrals have been associated with school
2 disengagements, lower graduation rates, increased dropout rates, and increased involvement in
3 the school-to-prison pipeline^{1, 2}; and
4

5 Whereas, School-related arrests and juvenile justice referrals disproportionately target black
6 students, Latino students, male students, and students with physical or mental disabilities^{3, 4, 5};
7 and
8

9 Whereas, Research on the effectiveness of school resource officer programs is limited, and fails
10 to make a strong case for harsh discipline programs that include referral to law enforcement⁶;
11 and
12

13 Whereas, School-based mental health efforts have been successful in identifying those in need
14 of mental health services, bolstering academic functioning, and improving patterns of behavior⁷;
15 and
16

17 Whereas, Educators, nurses, and counselors can play a key role in fostering protective
18 environments for children and identifying students who may need additional support, in contrast
19 to school resource officers^{8, 9}; and
20

21 Whereas, School-based mental health professionals report ever-increasing workloads and
22 responsibilities that include disciplinary roles^{10, 11}; and
23

24 Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental
25 health, or social issues because they do not feel that their disclosure will be kept private,
26 possibly affecting their academic or conduct standing¹²; and
27

28 Whereas, The American School Counselor Association urges that “school counselors maintain
29 non-threatening relationships with students to best promote student achievement and
30 development” and states that school counselors are neither “disciplinarians” or “enforcement
31 agent[s] for the school”¹³; and
32

33 Whereas, The National Association of School Nurses states that school nurses should facilitate
34 an “environment that values connecting students, families, and the community in positive
35 engagement” characterized by “safety and trust where students are aware that caring, trained
36 adults are present and equipped to take action on their behalf”¹⁴; and
37

38 Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based
39 implementation framework focusing on prevention and intervention strategies that support the

1 academic, social, emotional, and behavioral competence of students at all levels of education¹⁵;
2 and
3

4 Whereas, PBIS promotes prevention of student misbehavior by having students experience
5 "predictable instructional consequences for problem behavior without inadvertent rewarding"
6 while educators provide "clear and predictable consequences for problem behavior and
7 following up with constructive support to reduce the probability of future problem behavior"¹⁵;
8 and
9

10 Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344
11 elementary students to reduce concentration and behavioral problems, and increase social-
12 emotional functioning and prosocial behavior¹⁶; and
13

14 Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior,
15 and academics while decreasing office discipline referrals, in-school suspensions, and out-of-
16 school suspensions^{17, 18}; and
17

18 Whereas, Mental Health America and the American Academy of Pediatrics have recognized the
19 detrimental effects of "zero tolerance" policies and have advocated for school wide PBIS as an
20 alternative^{19, 20}; and
21

22 Whereas, AMA policy H-60.919 includes support for "school discipline policies that permit
23 reasonable discretion and consideration of mitigating circumstances when determining
24 punishments," but is largely focused on determination of punishment rather than prevention of
25 misbehavior; and
26

27 Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA
28 policy H-60.902 addresses the need for policy ensuring proper qualification and training for
29 school resource officers, but do not delineate if or how school-based health professionals
30 should participate in school disciplinary roles; therefore be it
31

32 RESOLVED, That our American Medical Association support evidence-based frameworks in
33 K-12 schools that focus on school-wide prevention and intervention strategies for student
34 misbehavior (New HOD Policy); and be it further
35

36 RESOLVED, That our AMA support the inclusion of school-based mental health professionals in
37 the student discipline process. (New HOD Policy)
38

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution addresses an important policy gap as it expands on the current policies that exists concerning school discipline. It asks AMA to work with education stakeholders to determine appropriate roles for mental-health professionals in schools, with particular respect to disciplinary processes. Policies H-345.977 and H-345.981 already allow for the inclusion of mental health screening in schools and encourage leveraging 'firstline contacts' to intervene with students such as those with repeat instances of misbehavior. This resolution, in contrast, focuses on the prevention of student misbehavior and the prioritization of their behavioral health outcomes.

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RELEVANT AMA POLICY**Juvenile Justice System Reform, H-60.919****Our AMA:**

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
(CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16)

School-Based and School-Linked Health Centers, H-60.921

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
(CSAPH Rep. 1, A-15)

Adolescent Health, H-60.981

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
(Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17)

Providing Medical Services Through School-Based Health Programs, H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

(CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)

Improving Pediatric Mental Health Screening, H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

(Res. 414, A-11; Appended: BOT Rep. 12, A-14)

Access to Mental Health Services, H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

- (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
- (2) improving public awareness of effective treatment for mental illness;
- (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
- (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
- (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
- (6) reducing financial barriers to treatment.

(CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18)

School Resource Officer Qualifications and Training, H-60.902

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

(Res. 926, I-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(JUN-21)

Introduced by: Delaware

Subject: Healthy Air Quality

Referred to: Reference Committee E

1 Whereas, Particulate matter (PM) or particle pollution is a mixture of solid particles and liquid
2 droplets found in the air that come in many sizes and shapes and can be made up of hundreds
3 of different chemicals¹; and
4

5 Whereas, Particulate matter inhaled can get deep into the lungs and even into the
6 bloodstream¹; and
7

8 Whereas, Particles less than 2.5 micrometers in diameter, also known as fine particles or PM
9 2.5, pose the greatest risk to health¹; and
10

11 Whereas, In 2016-2018, more cities had high days of ozone and short-term particle pollution
12 compared to 2015-2017 and many cities measured increased levels of year-round particle
13 pollution²; and
14

15 Whereas, Harmful revisions and setbacks to key protections currently in place or required under
16 the Clean Air Act of 1970 threaten to make air quality even worse in parts of the US²; and
17

18 Whereas, Atmospheric pollutants have been linked to a host of chronic and acute illnesses, and
19 contribute to the risk of COVID-19 complications, with preventable health, social, and economic
20 impacts³⁻⁸; and
21

22 Whereas, Evidence that both prenatal and postnatal exposures to PM 2.5 are associated with
23 later development of allergic rhinitis, a precursor to pediatric asthma, the vulnerable time
24 window may be within late gestation and the first year of life⁸; and
25

26 Whereas, Poor air and water quality disproportionately affect the economically disadvantaged
27 as well as communities of color^{3-5,7-9}; and
28

29 Whereas, Statistics for 2020 show the nation's electricity was generated from 60% of fossil
30 fuels, 20% from nuclear supplies and another 20% from renewable sources¹⁰; and
31

32 Whereas, Current technology is capable of replacing fossil fuel-generated power with renewable
33 sources^{7,11}; therefore be it
34

35 RESOLVED, That our American Medical Association champion legislation and policies at the
36 federal level to shift our energy generation away from polluting sources like fossil fuels and
37 toward less polluting renewables in order to drive down the generation of PM 2.5 and other
38 pollutants. (Directive to Take Action)

1

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Air pollution is the leading environmental health risk humans face. The combined effects of outdoor and household air pollution cause around seven million (one in eight) premature deaths every year, largely as a result of increased mortality from stroke, heart disease, lung disease, and cancers.

According to data from the World Health Organization (WHO), air quality in most cities fails to meet WHO guidelines for safe levels, putting people at additional risk of respiratory disease and other health problems. Without action, air pollution in many cities will continue to get worse.

Emerging research is shedding light on the links between air pollution and severe illness from COVID-19, underscoring the critical need to ensure healthy air for all. Researchers SUNY College of Environmental Science and Forestry found that an increase in exposure to hazardous air pollutants is associated with a 9% increase in death among patients with COVID-19, after accounting for differences in wealth and other health issues. Another study from the Harvard T.H. Chan School of Public Health and the Dana-Farber Cancer Institute looked at the impact of long-term exposure to fine particle pollution on COVID-19 death rates. Researchers found that just a small increase (1 microgram per cubic meter) in long-term average exposure to fine particle pollution is associated with an 11% increase in the COVID-19 death rate. Adding to the evidence on the connection between racial disparities, air pollution, and COVID-19, the researchers found a 49% increase in the COVID-19 death rate in counties with elevated fine particle pollution and that had a higher Black population.

While the COVID-19 pandemic is understandably treated as an imminent danger, the climate crisis is thought of as a consequence yet to come and that will be dealt with in the future.

The Medical Society of Delaware requests that our resolution, "Healthy Air Quality," be considered an urgent priority resolution for the upcoming Special Meeting of the AMA House of Delegates in June 2021 for these reasons. There is support from the Biden Administration to confront the climate crisis, to include protecting the air from harmful pollution. The time is now to make important changes for the health of our patients.

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RELEVANT AMA POLICY

Preventing Death and Disability Due to Particulate Matter Produced by Automobiles H-135.915

Our AMA will: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) support individual states' legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards.

Citation: Res. 915, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.

2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Citation: BOT Rep. 34, A-18

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16; Reaffirmation: I-19

EPA and Green House Gas Regulation H-135.934

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.

2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Protective NAAQS Standard for Fine Particulate Matter (PM 2.5) H-135.946

Our AMA supports more stringent air quality standards for particulate matter. We specifically request a NAAQS that provides improved protection for our patients which includes:

- 12 µg/m³ for the average annual standard
- 25 µg/m³ for the 24-hour standard
- 99th percentile used for compliance determination.

Citation: BOT Action in response to referred for decision Res. 720, I-05; Reaffirmed in lieu of Res. 507, A-09; Modified: CSAPH Rep. 01, A-19

Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10) D-135.978

At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.

Citation: BOT action in response to referred for decision Res. 926, I-10; Reaffirmed: Res. 915, I-19;

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.

Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

- (1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
- (2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
- (3) maintaining a global perspective on environmental problems;
- (4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
- (5) encouraging state and component societies that have not already done so to create environmental committees.

Citation: Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Citation: Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports

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

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

Global Climate Change - The "Greenhouse Effect" H-135.977

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

Federal Clean Air Legislation H-135.984

1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.

2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.

Citation: Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14)

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Reducing Sources of Diesel Exhaust D-135.996

Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the glider Kit Rule which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

Citation: Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14; Modified: Res. 521, A-18

Research into the Environmental Contributors to Disease D-135.997

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

Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19;

AMA Position on Air Pollution H-135.998

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

Citation: BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(JUN-21)

Introduced by: Pennsylvania

Subject: Personal Care Products Safety

Referred to: Reference Committee E

1 Whereas, The Federal Food, Drug, and Cosmetic (FD&C) Act that is designed to ensure the
2 safety of personal care products, referred to as "cosmetics" – including makeup, fragrance,
3 lotion, toothpaste, body wash, shampoo, deodorant and more – has remained largely
4 unchanged since the law was enacted in 1938; ¹ and

5
6 Whereas, FDA can pursue enforcement action against products on the market that are
7 "adulterated" or "misbranded" and against firms or individuals who violate the law,
8 manufacturers are not required to register in the Voluntary Cosmetic Registration Program and
9 FDA estimates that only one-third of firms file cosmetic product ingredient statements; ² and

10
11 Whereas, Although companies and individuals who manufacture or market cosmetics have a
12 legal responsibility to ensure the safety of their products, and the Cosmetic Ingredient Review
13 (CIR) Expert Panel that includes dermatologists, pathologists, toxicologists, and chemists set
14 standards for components of cosmetics, there are currently no legal requirements for
15 cosmetic manufacturers who market products to American consumers to test their products
16 for safety; ^{1, 3} and

17
18 Whereas, FDA lacks authority to issue mandatory recalls of products based on safety concerns
19 and can only warn consumers about contaminated products; and cosmetic firms are not
20 required to initiate recalls when FDA becomes aware of adulterated or misbranded cosmetic
21 products on the market; ² and

22
23 Whereas, Cosmetic firms are not required to provide any safety information to FDA even if
24 requested by FDA during an inspection; ² and

25
26 Whereas, States may have more extensive requirements for cosmetic manufacturers,
27 distributors, and packagers than exist federally, ⁴ while a nationwide standard would enable
28 more uniform regulatory oversight; and

29
30 Whereas, FDA regulatory oversight authority is limited and FDA faces challenges in identifying
31 and analyzing safety signals due to its lack of reliable and complete serious adverse event
32 report data; ² and

33
34 Whereas, Firms are not required to follow FDA draft guidance on good manufacturing practices
35 (GMPs) for cosmetics products; ² and

36
37 Whereas, The program for cosmetics at the Center for Food Safety and Applied Nutrition, FDA's
38 lead Center for the regulation of cosmetics, was approximately \$10 million or about three
39 percent of the Center's budget, despite 2,727,847 lines of cosmetics products imported into the

1 United States from 177 countries in FY 2018, an increase of more than one million lines of
2 annual cosmetic imports since one decade prior; ² and

3
4 Whereas, Based on different regulatory frameworks, there are few restrictions on materials that
5 a cosmetic manufacturer may use as a cosmetic ingredient without premarket approval from
6 FDA, ^{2, 5, 6} where the United States prohibits or restricts 11 types of harmful ingredients from
7 cosmetics, while the European Union has banned or restricted more than 1,300 chemicals ⁷
8 often due to absence of safety data rather than data that shows harm; ⁸ and

9
10 Whereas, Decisions should be evidence-based; 595 cosmetic manufacturers have reported
11 using 88 chemicals that have been linked to cancer, birth defects or reproductive harm in more
12 than 73,000 products since 2009, ^{4, 9} however, FDA has testified that most cosmetics on the
13 market in the United States are safe and in rare cases when safety issues arise many firms
14 work with FDA to address them; ² in addition a causative relationship between endocrine
15 disruption and cancer and the concentration of certain ingredients in cosmetic products “has not
16 been proven scientifically;” ^{10, 11} and

17
18 Whereas, Chemical use and concentration should be considered; researchers found that
19 permanent hair dye and straighteners were associated with an increased risk for breast cancer
20 ^{12, 13} and formaldehyde found in hair products can expose salon workers to health risks, ¹⁴,
21 however, parabens and formaldehyde releasers prevent severe infections and complications
22 such as the *Pseudomonas*-induced corneal ulcers from inadequately preserved mascara; ^{15, 16}
23 and

24
25 Whereas, FDA confirmed the presence of asbestos in makeup products sold by two different
26 retail stores, ^{17, 18, 19, 20} and asbestos exposure is associated with mesothelioma and cancers of
27 the lung, larynx, and ovary; and linked to increased risks of cancers of the stomach, pharynx,
28 and colorectum; ²¹ and

29
30 Whereas, FDA discovered elevated lead levels in a bentonite clay product sold online and in
31 retail outlets, and lead poisoning can lead to anemia, weakness, kidney and brain damage, and
32 death; and pregnant women who are exposed to lead will also expose their unborn child, which
33 can cause potentially serious health complications; ^{22, 23} and

34
35 Whereas, Restrictions should be evidence based; for example, propyl paraben is used in a wide
36 range of products, a finding of questionable significance in a topically applied personal care
37 product since parabens are poorly absorbed percutaneously, ¹⁰ studies have shown that some
38 parabens injected in very high doses were found to be thousands to millions of times weaker
39 than estradiol in rats and yeast cells, ^{11, 24} a study that claimed to find parabens in human breast
40 tumors lacked a control group and parabens were found in blank samples, ^{11, 25} and the CIR
41 extensively reviewed the scientific literature on paraben safety and concluded that the parabens
42 as currently used in personal care products in the United States are safe; ¹⁰ and

43
44 Whereas, AMA policy H-440.855 supports that FDA should be able to recall cosmetic products
45 that it deems to be harmful and supports creation of a publicly available registry, however, the
46 registry remains voluntary with limited participation by manufacturers; therefore be it

1 RESOLVED, That our American Medical Association advocate that the Food and Drug
2 Administration (FDA) be given the appropriate resources and authority to effectively regulate
3 and enforce standards for personal care products, including being authorized to mandate
4 registration and reporting by manufacturers, conduct appropriate inspections of manufacturing
5 facilities, ensure robust review of product safety, and require adherence with Good
6 Manufacturing Practices while allowing flexibility for small business to comply; and reaffirm
7 support for providing the FDA with sufficient authority to recall cosmetic products that it deems
8 to be harmful. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Pennsylvania Delegation would appreciate the committee considering its Resolution A-20, "Personal Care Products Safety," to be "High Priority" for the upcoming June HOD. Safety concerning products in personal cosmetics sold to American consumers is of utmost importance to both those who use them, and their physicians, who are responsible for the health and safety to some degree of all patients. Federal law designed to make sure laws are safe in this regard have not changed since 1938. Over time, only 11 chemicals identified in American cosmetics have been banned, as opposed to more than 1,300 in Europe. Clearly, we are way behind in providing safe cosmetics for American citizens. The personal care products needing safety scrutiny include hair, lotion, makeup, toothpaste, shampoo, deodorant, body wash and fragrance – all staples of use by millions of people in our country. Known carcinogenic chemicals previously identified in cosmetics include asbestos, hair dye and hair straighteners; lead, propyl paraben and formaldehyde are others with known adverse health effects that have been identified. Clearly, this is a public health hazard of extreme proportions that can be begun to be addressed by introducing new bipartisan legislation that requires the FDA to evaluate a minimum of 5 ingredients found in personal care products sold in the U.S. It behooves the AMA to take the lead in investigating the scope and extent of possible harm and injury of personal care safety products to U.S. consumers, who are all our patients.

References

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- ² <https://www.fda.gov/news-events/congressional-testimony/building-consumer-confidence-empowering-fda-improve-cosmetic-safety-12042019>
- ³ <https://www.cir-safety.org/about>
- ⁴ <https://www.cdph.ca.gov/Programs/CCDPPH/DEODC/OHB/CSCP/Pages/SummaryData.aspx>
- ⁵ <https://www.fda.gov/cosmetics/resources-consumers-cosmetics/cosmetics-safety-qa-prohibited-ingredients>
- ⁶ <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/prohibited-restricted-ingredients-cosmetics>
- ⁷ <https://data.europa.eu/euodp/en/data/dataset/cosmetic-ingredient-database-2-list-of-substances-prohibited-in-cosmetic-products>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(JUN-21)

Introduced by: Pennsylvania

Subject: Wireless Devices and Cell Tower Health and Safety

Referred to: Reference Committee E

1 Whereas, Industry propaganda is masking and mitigating the scientific evidence showing
2 concerning biological effect to pulsated microwave and millimeter wave electromagnetic fields
3 (EMF), the type of radiation emitted from all of our wireless devises (cell phones, cell phone
4 towers, WiFi, computers, smart TV, smart meters, bluetooth, etc); and
5

6 Whereas, Most citizens are under the false impression that there are bonafide safety guidelines
7 set forth by the FCC. The safety guidelines, established in 1996 under the leadership of
8 telecommunications lobbyist Tom Wheeler, are ONLY based on an erroneous assumption that
9 microwaves are dangerous when they heat liquids up (so-called "thermal" EMF), much like a
10 microwave oven; and
11

12 Whereas, Now there is overwhelming scientific evidence that non-thermal EMFs can cause
13 significant health effects at levels that are orders of magnitudes lower than those allowed by
14 these FCC guidelines; and
15

16 Whereas, The data shows that fetuses and children are far more vulnerable to these effects, as
17 they have higher surface to volume ratios, high densities of stem cells, a developing brain, and
18 tissue with greater extracellular water leading to deeper penetration effects; and
19

20 Whereas, Based on the 1996 Telecommunications Act, local jurisdictions do not have the right
21 to approve or disapprove the placement of cell tower based on safety or health reasons. In the
22 last two years, Verizon and AT&T have tried twice to convince the PA General Assembly to
23 approve a bill that further preempts municipal rights for managing 5G cell towers in the public
24 rights-of-way; therefore be it
25

26 RESOLVED, That our American Medical Association oppose legislation that blocks the public's
27 right to guard its own safety and health regarding cell tower placement (Directive to Take
28 Action); and be it further
29

30 RESOLVED, That our AMA promote ways to reduce radiation exposure from wireless devices,
31 especially for pregnant women and children (wired devices preferable to wireless, shielding,
32 etc.). (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

With the pervasiveness of wireless communication in our present-day society, the resolution is concerned with the possible effects of EMF (electromagnetic field) on humans, particularly the more vulnerable such as children and fetuses.

It is felt that the standards for such safety, established in 1996, were biased by lobbyist, and exclusive of other scientific criteria. Furthermore, the telecommunications act of 1996 usurps local jurisdiction on the placement of telecommunication towers.

It is therefore requested that our AMA oppose legislation that may block the public's "access to know" in these matters and foster shielding of EMF effects from wireless devices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(JUN-21)

Introduced by: Colorado, American Academy of Ophthalmology, GLMA: Health Professionals Advancing LGBTQ Equality, American Society of Cataract and Refractive Surgery

Subject: Evidence-Based Deferral Periods for MSM Donors of Blood, Corneas and Other Tissues

Referred to: Reference Committee E

1 Whereas, On May 20, 1994, the US Public Health Service instituted a policy prohibiting
2 donation of corneas and other tissues by “[men] who have had sex with another man [MSM] in
3 the preceding 5 years” even if all required infectious disease testing is negative,¹ a policy which
4 continues to be enforced today by the US Food and Drug Administration (FDA)²; and
5

6 Whereas, The 5-year MSM deferral policy was instituted at a time when HIV tests were
7 unreliable and has not been updated to reflect advances in HIV testing since 1994^{3,4}; and
8

9 Whereas, All corneal donors are required to undergo HIV testing, which is now reliable within
10 4-8 days of viral exposure^{5,6}; and
11

12 Whereas, No case of HIV transmission from a corneal transplant has ever been reported, even
13 in cases when the corneal donors were HIV-positive^{3,7,8,9,10,11}; and
14

15 Whereas, Corneas are an avascular tissue and are not a major reservoir of HIV¹²; and
16

17 Whereas, Current FDA policy treats MSM corneal donors more strictly than other potentially
18 high-risk donors (e.g. while MSM donors must be abstinent for 5 years, heterosexual donors in
19 a sexual relationship with someone known to be HIV-positive are only ineligible for 1 year after
20 last sexual contact with an HIV-positive individual)²; and
21

22 Whereas, MSM blood donors are only ineligible for 3 months after last sexual contact, despite
23 the known risk of HIV transmission through blood transfusions¹³; and there is no deferral period
24 whatsoever for MSM donors of solid organs (such as hearts, lungs, kidneys, etc.)^{14,15}; and
25

26 Whereas, Many peer nations have no deferral period for MSM corneal donors whatsoever (e.g.
27 Spain,¹⁶ Italy,¹⁷ Mexico,¹⁸ Chile,¹⁹ Argentina,²⁰ Germany,²¹ Denmark,²² South Africa²³); and
28

29 Whereas, Many other peer nations have deferral periods for MSM corneal donors far shorter
30 than 5 years (e.g. 3 months in the United Kingdom,²⁴ 4 months in the Netherlands,²⁵ 4 months in
31 France,²⁶ 12 months in Canada²⁷); and
32

33 Whereas, AMA Policy H-50.973, “Blood Donor Deferral Criteria,” states that AMA supports
34 blood donor deferral criteria that are “representative of current HIV testing technology” but does
35 not address the FDA’s even stricter deferral criteria for MSM donors of corneas and other
36 tissues²⁸; and

Whereas, A recent *JAMA Ophthalmology* study estimated that between 1558 and 3217 potential corneal donations were disqualified in 2018 alone in the United States and Canada due to the two countries' bans on MSM corneal donors³; and

Whereas, An estimated 12.7 million visually impaired patients are in need of corneal transplant surgery worldwide, with only 1 cornea donated for every 70 corneal transplants needed²⁹; therefore be it

RESOLVED, That our American Medical Association amend current policy H-50.973, "Blood Donor Deferral Criteria," by addition and deletion as follows:

Blood and Tissue Donor Deferral Criteria

Our AMA: (1) supports the use of rational, scientifically-based ~~blood and tissue donation~~ deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and tissue donation (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM donors of corneas and other tissues. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We believe this resolution meets all the criteria to be classified as "High Priority."

Corneal transplantation is the most commonly performed transplant surgery in the United States, yet there is only 1 cornea donated for every 70 corneal transplants needed worldwide. A recent *JAMA Ophthalmology* study estimated that up to 3217 blind patients a year are deprived of vision-restoring surgery due to outdated FDA policy banning corneal donation by men who have had sex with another man in the preceding 5 years, even if all infectious disease testing is negative.

AMA has spoken clearly and repeatedly to advocate for evidence-based guidelines for MSM *blood* donation, yet AMA has never previously advocated for changes to the FDA's separate policies preventing MSM donation of corneas and other tissues. This represents a substantial gap in AMA policy. Arguing for evidence-based health policy and for equitable treatment of the LGBTQ community is consistent with AMA's mission and existing policy.

Since the FDA's policy for MSM corneal donors is classified as *regulatory guidance* and not as an official regulation, the FDA could change its stance on this issue through a simple press release, without requiring an act of Congress or a formal "notice and comment" process. The relative bureaucratic ease of this change means that there is a realistic chance that AMA advocacy could convince the FDA to act. Any further delay would continue to deprive thousands of blind patients of vision-restoring surgery, while allowing an inequitable health policy against the LGBTQ community to endure.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(JUN-21)

Introduced by: Mississippi, New Jersey, Puerto Rico, South Carolina, Oklahoma

Subject: \$100 Member Annual Dues Payment Through 2023

Referred to: Reference Committee F

1 Whereas, Many physician practices have struggled during the unprecedented COVID-19
2 pandemic with economic viability over the past year as a result of decreased revenue and
3 increased expenses due to the pandemic; and
4

5 Whereas, Reimbursement cuts continue to loom on the horizon for physician practices; and
6

7 Whereas, In the face of decreasing patient volume, increasing expenses, and reimbursement
8 cuts, physicians have had to make difficult choices to maintain their practices; and
9

10 Whereas, Many physicians have elected not to renew their memberships in their professional
11 organizations, including the American Medical Association as evidenced by the fact that our
12 AMA has seen a drop in actively practicing physician membership as noted in the report
13 provided to us in January 2021; and
14

15 Whereas, Our AMA is the most important voice representing America's doctors across all
16 specialties and all stages and modes of practice; and
17

18 Whereas, That voice is too important to allow a declining membership to weaken our
19 effectiveness; and
20

21 Whereas, Based on 2019 data, membership dues revenue provides less than 8% of the total
22 revenue (less that 7% in net revenue) to our annual AMA budget; and
23

24 Whereas, Our AMA has an opportunity to not only increase our membership but also
25 recognize the heroic sacrifice that our existing AMA members have made in responding to
26 the pandemic; therefore be it
27

28 RESOLVED, That our American Medical Association adjust dues to \$100 per year for a trial
29 period of two years for actively practicing physicians and senior physicians. (Directive to Take
30 Action)

Fiscal Note: Cost to implement this resolution is \$20.9 million annually.

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

During the pandemic crisis, many physician practices have struggled because of decreasing revenue and increasing expenses. Many physicians have had to make difficult choices including the renewal of memberships in professional organizations such as the American Medical Association. The AMA is the leading voice of America's doctors and this voice should not be muzzled because members and potential members cannot afford the dues. We feel this 2 year time limited resolution should be brought before the House of Delegates urgently to make sure that physicians are taken care of during their time of need.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(JUN-21)

Introduced by: Senior Physicians Section

Subject: Timely Promotion and Assistance in Advance Care Planning and Advance Directives

Referred to: Reference Committee F

1 Whereas, Every human being will confront mortality, and it is widely acknowledged that medical
2 care and decision making at the end-of-life are best managed both ethically and medically with
3 the use of Advance Directives;^{1,2} and
4

5 Whereas, The COVID-19 pandemic has dramatically increased the number of people facing life
6 threatening illness and even end-of-life decisions, concomitant with limited or no access to their
7 loved ones at the bedside, which has exponentially increased stress on physicians and others
8 caring for critically ill patients; and
9

10 Whereas, The recent resurgence in COVID infections, hospitalizations and deaths makes this a
11 continuing high priority issue under the J-21 HOD Prioritization Matrix; and
12

13 Whereas, Advance directives specify the extent of care a person wishes when they are unable
14 to make medical decisions for themselves and often, due to hospital isolation requirements
15 under COVID-19, no one is available to speak for them; and
16

17 Whereas, The use of advance directives has been shown to bring comfort, closure,
18 peace-of-mind, and family support to patients and to physicians providing critical and terminal
19 care, while also reducing healthcare costs; and
20

21 Whereas, Advance directives are legal in every state, at no, or very low cost, and easily fillable
22 forms are readily available from a variety of sources, e.g., MOLST /POLST, and MyDirectives,
23 including local medical organizations, AARP, state governments, faith-based groups, hospitals,
24 and others, yet are underutilized; and
25

26 Whereas, AMA Code of Ethics Opinion 5.1, "Advance Care Planning," encourages physicians
27 and patients to plan in advance for decisions about care in the event of a life-threatening illness
28 or injury, emphasizes that such discussions should not begin only after a potentially fatal illness
29 or injury has befallen a patient, and urges that physicians should regularly encourage all
30 patients, regardless of age or health status to consider these issues, periodically review with
31 them their goals, preferences, and chosen decision maker, and include notes from these
32 conversations in medical records; and
33

34 Whereas, AMA Code of Ethics Opinion 5.2, "Advance Directives," discusses the importance of
35 documenting advance care planning discussions; and

1 Whereas, Despite ethical directives, studies show that only about 37% of Americans have
2 completed advance directives and physicians have also been shown to be lax in modeling this
3 beneficial health practice;³ and
4

5 Whereas, The substantially lower rate of completion of advance directives among minority
6 populations has been identified as a health disparity and equity issue, bringing this concern
7 squarely into one of the highest priority areas for our AMA; and
8

9 Whereas, The source preferred by patients for information about advance care planning is their
10 own physician, and advance care planning discussions between a physician and a patient are
11 now reimbursable, yet advance care planning has still not become a routine part of medical
12 practice; and despite past AMA recommendations and ethical guidelines, Advance Directive
13 forms are not yet fully integrated as part of the medical record; and
14

15 Whereas, Advance directives, when not completed by patients or when not available to
16 providers because they are not included in the medical record, may not be found, considered
17 by, or honored by providers, prompting ethical concerns¹ and moral distress⁴; therefore be it
18

19 RESOLVED, That our American Medical Association begin a low cost in-house educational
20 effort aimed at physicians, to include relevant billing and reimbursement information,
21 encouraging physicians to lead by example and complete their own advance directives
22 (Directive to Take Action); and be it further
23

24 RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of
25 having executed our own advance directives, and to share readily available educational
26 materials regarding the importance and components of advance directives in offices and on
27 practice websites, as a way of starting the conversation with patients and families (Modify
28 Current HOD Policy); and be it further
29

30 RESOLVED, That our AMA strongly encourage all primary care physicians to include advance
31 care planning as a routine part of their adult patient care protocols, and also to include advance
32 directive documentation in patients' medical records as a suggested standard health
33 maintenance practice (Modify Current HOD Policy); and be it further
34

35 RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing
36 COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical
37 education, and faith-based communities as well as interested citizens, to promote completion of
38 advance directives by all individuals who are of legal age and competent to make healthcare
39 decisions (Directive to Take Action); and be it further
40

41 RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as
42 National Healthcare Decisions Day. (New HOD Policy)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents a high, but not a top priority issue for our AMA. This resolution affects all physicians and patients, with a greater potential impact on senior physicians and patients who have increased vulnerability both to infection and death from Covid. Additionally, lack of AD has disproportionately affected underrepresented or disadvantaged patient populations.

As we near 600,000 deaths from Covid-19 (up to 63% of whom may not have had AD) with frontline colleagues daily facing the distress of making life and death decisions for patients unable to speak for themselves (and pandemic policies preventing family members at the bedside) there is a high likelihood of ongoing negative impact if we continue to overlook this issue, and do not act now to encourage active modeling and facilitation of creation of AD. Modeling healthful behaviors by physicians is consistent with our mission and strategic plan. The resolution calls for action that is likely to have meaningful impact, and requires a more proactive approach, incorporating the rationale and evidence for more active promotion of existing policy or significant modification of current policy, so as to immediately begin to address this important issue.

AMA has prior policy on this issue, but an important gap exists in that there has not been evidence of active implementation of existing policy. An AMA resolution is one of the most appropriate avenues to address this issue.

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RELEVANT AMA POLICY

H-85.950 - Support of a National Registry for Advance Directives
H-85.956 - Educating Physicians About Advance Care Planning
H-390.916 - Payment for Patient Counseling Regarding Advance Care Planning
D-140.968 - Standardized Advance Directives
E-5.1 Code of Medical Ethics - Advance Care Planning
E-5.2 Code of Medical Ethics - Advance Directives

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(JUN-21)

Introduced by: American Association of Public Health Physicians

Subject: AMA Urges Health & Life Insurers to Divest From Investments in Fossil Fuels

Referred to: Reference Committee F

1 Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by
2 global climate change,¹ which on its current trajectory is likely to far exceed the health impacts
3 of COVID-19 and HIV combined; and
4

5 Whereas, Our AMA “recognizes the importance of physician involvement in policymaking at the
6 state, national, and global level and supports efforts to search for novel, comprehensive, and
7 economically sensitive approaches to mitigating climate change to protect the health of the
8 public; and recognizes that whatever the etiology of global climate change, policymakers should
9 work to reduce human contributions to such changes”¹; and
10

11 Whereas, In 2018, our AMA pledged that, “our AMA, AMA Foundation, and any affiliated
12 corporations will work in a timely, incremental, and fiscally responsible manner, to the extent
13 allowed by their legal and fiduciary duties, to end all financial investments or relationships
14 (divestment) with companies that generate the majority of their income from the exploration for,
15 production of, transportation of, or sale of fossil fuels,” with companion policy to “support efforts
16 of physicians and other health professional associations to proceed with divestment”²; and
17

18 Whereas, In the past, many health and life insurance companies followed the example of the
19 AMA by divesting from tobacco companies because the tobacco industry’s products and
20 marketing strategies so clearly damage human health; and
21

22 Whereas, Moody’s Investors Service warned investors in 2017 that the oil and gas industry
23 faces significant credit risks due to the world’s ongoing transition away from fossil fuel³; and
24

25 Whereas, The oil and gas industry stock prices have been the poorest performing sector of
26 world stock markets since 2008, a period during which the prices of most other sectors have
27 risen dramatically; and
28

29 Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are
30 publicly disclosed fossil fuel investment data, have invested nearly \$24 billion in fossil fuels
31 companies⁴; and
32

33 Whereas, Collectively, the largest nineteen health or life insurance companies have declared
34 investments of more than \$183 billion in the fossil fuel industry⁴; therefore be it
35

36 RESOLVED That our American Medical Association declare that climate change is an urgent
37 public health emergency, and call upon all governments, organizations, and individuals to work
38 to avert catastrophe (Directive to Take Action); and be it further

1 RESOLVED, That our AMA urge all health and life insurance companies, including those that
 2 provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and
 3 fiscally responsible manner to end all financial investments or relationships (divestment) with
 4 companies that generate the majority of their income from the exploration for, production of,
 5 transportation of, or sale of fossil fuels (New HOD Policy); and be it further
 6

7 RESOLVED, That our AMA actively inform the largest health insurance and life insurance
 8 companies, and the associations representing those companies, about AMA policies concerned
 9 with climate change and with fossil fuel divestment, and will encourage such companies and
 10 associations to take similar actions (Directive to Take Action); and be it further
 11

12 RESOLVED, That our AMA report the status of AMA's implementation of our 2018 fossil fuels
 13 divestment policies (D-135.969 and H-135.921), as well as the implementation of this resolution,
 14 to the 2021 Interim Meeting of the House of Delegates. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This is a Top Priority Resolution according to the AMA Prioritization Matrix:

- Affects most or all physicians and/or their patients: Climate change is the most important public health issue facing the world in 21st Century with already a disproportionate share of the health impacts being faced by economically disadvantaged populations. The resulting health and political chaos, already involving regional wars and perhaps worse, will not spare any populations of substantial size in the world.
- Not acting at this meeting is likely to have a seriously deleterious impact: Each year that the world fails to take meaningful action is aggravating the health impacts of climate change. Our AMA has a unique and influential voice within the health care and Public Health sectors. We must use this voice, urgently, at each opportunity.
- Consistent with our mission and strategic plan: The betterment of public health requires protection of the human environment against humanity's most urgent threats.
- Calls for near-term important action and requires new policy to implement: Climate disruption is urgent. We have opportunity to use our AMA's voice now. That voice will be influential.
- No current policy exists on this topic, and it is an important issue on which to have policy: Our AMA's existing policy applies to our AMA, to its subsidiaries, and to health professionals and associations. Health and life insurers have very large investments, about which our AMA has no current policy.
- AMA action or policy statement will have a positive impact: AMA's voice, applied to insurers and in the public arena, is likely to be highly influential.
- AMA is most appropriate to tackle this issue, i.e., issue is not better handled by a specialty society or other group/organization: Because of its longstanding advocacy for the public interest and public health, our AMA has a uniquely credible, and uniquely influential, voice on this topic. The special relationships of physicians with the health insurance industry make it important that AMA speak out on this aspect of the issue of climate change. Success in this area will serve as an example to others, and will reduce the "moral hazard" in which those who profit from climate change stay silent when they should speak up.

References:

1. AMA Policy H-135.938, "Global Climate Change and Human Health", accessed May 12, 2021.
2. AMA Policies D-135.969 & H-135.921, "AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies", accessed May 12, 2021.

3. https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR_365728 , Accessed April 30, 2021.

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19;

Reaffirmation: I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

Citation: BOT Rep. 34, A-18;

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.

2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Citation: BOT Rep. 34, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(JUN-21)

Introduced by: Jerry P. Abraham, MD, Delegate

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee F

1 Whereas, The Lancet Countdown on health and climate change has warned that "A rapidly
2 changing climate has dire implications for every aspect of human life, exposing vulnerable
3 populations to extremes of weather, altering patterns of infectious disease, and compromising
4 food security, safe drinking water, and clean air"¹ earning it the title of the "greatest public health
5 challenge of the 21st century";² and

6
7 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050
8 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition *alone*³, without
9 factoring in the myriad other ways that climate change acts as a health risk multiplier; and

10
11 Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable
12 to the particulate matter (PM) 2.5 of planet-warming fossil-fuels, constituting nearly 18% of
13 premature deaths⁴; and

14
15 Whereas, Burning fossil fuels and other greenhouse gas (GHG) emissions have already caused
16 a rise in the global average temperature of 1.2°C and our changing climate is already producing
17 considerable shifts in the underlying social and environmental determinants of health at the
18 global level⁵; and

19
20 Whereas, Across all climate risks, children, older adults, low-income communities, outdoor
21 workers⁶ some communities of color, communities disproportionately burdened by poor
22 environmental quality⁷, some communities in the rural Southeastern United States⁸ and those
23 experiencing discrimination are disproportionately affected by extreme weather and climate
24 events, partially because they are often excluded in planning processes,⁹ and

25
26 Whereas, Many climate change mitigation interventions have immediate local air quality
27 benefits--among others-- and thus immediate health co-benefits¹⁰ which is part of why near-term
28 benefits outweigh climate solution costs in many areas;¹¹ and

29
30 Whereas, According to the latest available science, to limit warming to 1.5°C and achieve the
31 Paris Agreement goals would require global greenhouse gas (GHG) emissions to have peaked
32 by 2020 and be reduced to zero by around 2050¹², thus we are in a vanishing window of
33 opportunity for meaningful action; and

34
35 Whereas, Physicians are uniquely trusted messengers¹³, with a unique responsibility to
36 advocate politically for policies to safeguard health in the face of any public health crisis--
37 whether the COVID-19 pandemic, the need for tobacco and firearm regulation or the climate
38 crisis--in order to build social will for science-based policy action; and

Whereas, Our AMA House of Delegates has adopted multiple policies addressing climate change (H-135.919, [H-135.938](#), H-135.977, H-135.923, D-135.968, D-135.969, H-135.973), but these policies fall short of coordinating strategic physician advocacy leadership on the scale necessary for such a health crisis; and

Whereas, In the face of the existential threat that the climate crisis poses, these policies have not been leveraged to fulfill our AMA's *Declaration of Professional Responsibility* ([H-140.900](#)) in which '*We, the members of the world community of physicians, solemnly commit ourselves to 'Medicine's Social Contract with Humanity' in order to continue to earn society's trust in the healing profession, by, among other oaths, promising that we will 'Educate the public and polity about present and future threats to the health of humanity', and 'Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being,'* and

Whereas, Our AMA has no identified longitudinal body or center for coordinating and centralizing the Association's efforts to address climate change which the WHO calls "the greatest threat to global health in the 21st century;"¹⁴ therefore be it

RESOLVED, That our American Medical Association establish an internal, climate crisis-focused center for the purpose of fulfilling our social contract with humanity in this global public health crisis by determining the highest-yield advocacy and leadership opportunities for physicians, and for coordinating, strengthening and centralizing our AMA's efforts toward advocating for an equitable and inclusive transition to a net-zero carbon society by 2050. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution sits at the intersection of climate change, human health, and social justice. The authors and contributors believe this resolution needs to be passed this summer because with the current administration, there is a critical political window to enact change in the climate policy and environmental justice spaces-- and our AMA is not fully-prepared to lead on this public health crisis. Biden's team has listed climate change as one of four top priorities this year and a number of climate-focused bills have already been introduced in the 117th Congress. NASA analyses show in no uncertain terms that the Earth's average temperature in 2020 *tied with 2016 as the warmest year on record. The last seven years have been the warmest seven years on record.* An accelerating, unstable climate is incompatible with human health and safety.

This year also marks the 26th UN Climate Change Conference (AKA climate COP), in November in Glasgow, Scotland. This year's COP26 is anticipated to be the most important international climate summit since the Paris Agreement made at COP21 in 2015. COVID-19 has demonstrated the morbidity and mortality costs paid when politics ignore what the science clearly calls for, and the critical leadership of physicians in the face of global public health crises. To fulfill our social contract with humanity, we, as America's physicians must organize our AMA's advocacy on climate to lead for public health-- now is the time.

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2. Watts N, Amann M, Arnell N, et al. The 2019 report of The Lancet Countdown on health and climate change: ensuring that the health of a child born today is not defined by a changing climate. *The Lancet*. 2019;394(10211):1836-1878. doi:10.1016/s0140-6736(19)32596-6
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14. WHO calls for urgent action to protect health from climate change – Sign the call. World Health Organization. <https://www.who.int/globalchange/global-campaign/cop21/en/#:~:text=Climate%20change%20is%20the%20greatest,to%20current%20and%20future%20generations>. Published April 14, 2016. Accessed May 5, 2021.

RELEVANT AMA POLICY**H-135.919 Climate Change Education Across the Medical Education Continuum**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education. [Res. 302, A-19]

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on

environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19]

H-135.977 Global Climate Change - The "Greenhouse Effect"

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population. [CSA Rep. E, A-89 Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. [Res. 924, I-16 Reaffirmation: I-19]

D-135.968 Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership

Our AMA will continue to explore environmentally sustainable practices for JAMA distribution. [BOT Rep. 8, I-19]

D-135.969 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. [BOT Rep. 34, A-18]

H-135.973 Stewardship of the Environment

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects

resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. [CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending G-630.140 Lodging, Meeting Venues, and Social Functions

Referred to: Reference Committee F

1 Whereas, The seven regions of the AMA Medical Student Section (MSS) are a primary link
2 between the national initiatives of the MSS and student members at the section level; and
3

4 Whereas, In the fall of 2018, our AMA started a pilot program hosting individual, geographically-
5 separate MSS Region Meetings with the goal of strengthening Region cohesion, fostering inter-
6 student mentorship, and enriching the student experience; and
7

8 Whereas, The pilot included geographically separate MSS Region Meetings hosted in each
9 individual Region, which stemmed from feedback received from 2015 to 2018, when all Region
10 meetings were held simultaneously, in conjunction with Advocacy Day in Washington, DC; and
11

12 Whereas, During this period of time, MSS leadership and staff received reports that students
13 had difficulty attending Region meetings due to financial constraints on travel to Washington,
14 DC and the inflexibility of holding all Region meetings on one day; and
15

16 Whereas, Through the Region Meetings pilot program, six Regions planned and held Region
17 Meetings between January and February 2019; and
18

19 Whereas, Region 3 was limited in organizing their Region Meeting due to AMA Policy G-
20 630.140 Lodging, Meeting Venues, and Social Functions, which was amended at A-17 to
21 ensure that future AMA-organized or -sponsored meetings do not take place in towns, cities,
22 counties, or states with discriminatory policies; and
23

24 Whereas, G-630.140 with the amendment currently restricts the AMA from organizing or
25 sponsoring meetings in Alabama, Kansas, Kentucky, Mississippi, North Carolina, Oklahoma,
26 South Dakota, Tennessee, and Texas; and
27

28 Whereas, Based on the list of restricted states, Region 3 cannot hold Region meetings in four of
29 their six states (Kansas, Mississippi, Oklahoma, Texas), and the two remaining states
30 (Arkansas, Louisiana) are not centrally located; and
31

32 Whereas, Region 3 held their Region Meeting in Louisiana, and received multiple reports from
33 students about the difficulty of attending the Region Meeting based on travel distance; and
34

35 Whereas, Based on the list of restricted states, Region 1 cannot hold meetings in South Dakota,
36 Region 4 cannot hold meetings in three of their six states (Alabama, North Carolina,
37 Tennessee), and Region 5 cannot hold meetings in Kentucky; and

1 Whereas, The AMA Board of Trustees in conjunction with AMA legal counsel determined that
2 Region Meetings do not qualify for exemption from G-630.140 as a special circumstance without
3 further amendment of the policy; and
4

5 Whereas, While G-630.140 should continue to be enforced for national meetings such as
6 Annual and Interim to uphold the AMA's commitment to non-discrimination, enforcement for
7 Region Meetings reduces participation in small gatherings for students who are financially and
8 temporally limited in their ability to travel, especially in disproportionately affected Regions; and
9

10 Whereas, The MSS is the only section that has thus far been affected by the amendment to G-
11 630.140, making it the most appropriate body to bring this concern to the HOD; therefore be it
12

13 RESOLVED, That our American Medical Association amend AMA policy G-630.140, "Lodging,
14 Meeting Venues, and Social Functions," by addition to read as follows:
15

16 LODGING, MEETING VENUES, AND SOCIAL FUNCTIONS, G-630.140

17 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions
18 based on size, service, location, cost, and similar factors.

19 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly
20 Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

21 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be
22 held in a town, city, county, or state that has enacted comprehensive legislation requiring
23 smoke-free worksites and public places (including restaurants and bars), unless intended
24 or existing contracts or special circumstances justify an exception to this policy, and our
25 AMA encourages state and local medical societies, national medical specialty societies,
26 and other health organizations to adopt a similar policy.

27 4. It is the policy of our AMA not to hold national meetings organized and/or primarily
28 sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee
29 dues in any club, restaurant, or other institution, that has exclusionary policies, including,
30 but not limited to, policies based on, race, color, religion, national origin, ethnic origin,
31 language, creed, sex, sexual orientation, gender, gender identity and gender expression,
32 disability, or age unless intended or existing contracts or special circumstances justify an
33 exception to this policy.

34 5. Our AMA staff will work with facilities where AMA meetings are held to designate an
35 area for breastfeeding and breast pumping. (Modify Current HOD Policy)
36

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution has been pending since June 2019, and its adoption is paramount for our delegation's local meetings. Our leadership has already engaged in conversations with our AMA Board of Trustees and AMA legal counsel, and were told that a revision to existing policy is required. It addresses the issue of an undue logistical and financial burden for several MSS Regions regarding travel to their Regional Meetings, stemming from current policy that prohibits hosting AMA-sponsored meetings in states with discriminatory laws

As a specific example, Region 3 of the AMA-MSS consists of 6 states, 4 of which are prohibited from holding meetings. Texas is one such state that is prohibited from hosting the meeting, despite being centrally located and home to 90% of the Region 3 membership. We believe that this amendment to existing policy strikes a balance between ensuring that the AMA as an organization stands against discriminatory policies, while enabling its members in smaller gatherings to continue to collaborate and organize, often times working against these same policies. The impact of small gatherings, such as Region meetings, on the repeal of discriminatory policies is much lower and often negligible, while the impact of having to travel further has a significant impact on the ability of students to attend meetings, for both reasons of funding and time spent in travel. Many of these students are strong advocates and will progress to become physician advocates, so we believe it important to foster their development.

RELEVANT AMA POLICY

Lodging, Meeting Venues, and Social Functions G-630.140

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. BOT Rep. 17, A-17

Meeting Calendar and Locations G-600.130

AMA policy on the meeting calendar for the House includes the following: (1) Our AMA should make reasonable efforts to avoid scheduling future Annual Meetings that conflict with Father's Day weekend; (2) The Interim Meeting of the House of Delegates will be held in the second or third week in November; and (3) Our AMA supports scheduling more meetings in Washington, DC, specifically including Interim Meetings of the House on a rotating schedule as frequently as practicable. Our AMA believes, however, that it would not be financially prudent to hold all Interim Meetings in Washington, DC, nor would such a decision be equitable for other regions of the country. BOT Rep. I, I-90; BOT Rep. 36, A-94; BOT Rep. 1, I-98; Modified: Speakers Advisory Committee Rep., A-99; Reaffirmed: Sunset Report, I-00; Resolution 609, A-01; Consolidated: CLRPD Rep. 3, I-01; Appended: Res. 610, A-02; Appended: Res. 609, A-04; Reaffirmed in lieu of Res. 609, A-06; CC&B Rep. 3, I-08; CCB/CLRPD Rep. 3, A-12; Modified: Res. 606, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(JUN-21)

Introduced by: Medical Student Section

Subject: AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

Referred to: Reference Committee F

1 Whereas, Given the 100,120 reported firearm injuries and 36,383 reported firearm deaths in the
2 United States each year on average and the significant financial burden that the gun violence
3 epidemic poses on society, the AMA recognizes that gun violence represents a public health
4 crisis in our country (D-145.995)¹⁻³; and

5
6 Whereas, Laws that required a heightened showing of suitability for concealed carry, such as
7 universal background checks and “may issue” laws, and laws that prohibit gun possession by
8 people convicted of violent misdemeanors, were found to be associated with lower firearm
9 homicide rates⁴; and

10
11 Whereas, The AMA has adopted several policies demonstrating support for increased
12 regulation of firearm sales as well as research into the efficacy of different regulations (H-
13 145.997, H-145.975, H-145.972, H-145.996, H-145.985)⁵; and

14
15 Whereas, The Dickey Amendment currently prevents the Centers for Disease Control and
16 Prevention from using funding to advocate for and promote gun control, but does not place an
17 explicit ban on gun violence research⁷; and

18
19 Whereas, The AMA political action committee continues to make donations to politicians who
20 vote in opposition to aforementioned firearm regulation policies, donating \$54,889 combined to
21 17 candidates in 2018 who were also financed by the National Rifle Association and received A-
22 ratings from the National Rifle Association ^{6,8-9}; and

23
24 Whereas, Political ratings are used to measure a politician’s alignment with the mission of the
25 National Rifle Association and overall support for firearm regulation^{9,10}; and

26
27 Whereas, 141 Congress members received donations from both physician organization PACs
28 and the NRA PVF in 2018, and with one exception, sitting NRA-backed congress members who
29 received funds from physician organizations voted on policies not in keeping with physician
30 recommendations, including opposing legislation to require universal background checks, and to
31 prevent individuals prohibited from owning a firearm from utilizing shooting ranges^{8,10}; and

32
33 Whereas, The National Rifle Association Institute for Legislative Action denies the existence of
34 the “gun show loophole,” opposes expanding firearm background check systems, and opposes
35 firearm registration, contradicting AMA policy supporting expansion of background checks and
36 registration of firearms (H-145.996)¹¹; and

37
38 Whereas, The AMA has called upon all candidates for public office to refuse contributions from
39 tobacco companies and their subsidiaries (G-640.020); therefore be it

1 RESOLVED, That our American Medical Association amend policy G-640.020 by addition to
2 read as follows:

3
4 G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS

5 Our AMA: (1) Believes that better-informed and more active citizens will result in better
6 legislators, better government, and better health care; (2) Encourages AMA members to
7 participate personally in the campaign of their choice and strongly supports
8 physician/family leadership in the campaign process; (3) Opposes legislative initiatives
9 that improperly limit individual and collective participation in the democratic process; (4)
10 Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment
11 and support of political candidates; (5) Encourages AMPAC to continue to consider the
12 legislative agenda of our AMA and the recommendations of state medical PACs in its
13 decisions; (6) Urges members of the House to reaffirm their commitment to the growth
14 of AMPAC and the state medical PACs; (7) Will continue to work through its constituent
15 societies to achieve a 100 percent rate of contribution to AMPAC by members; ~~and~~ (8)
16 Calls upon all candidates for public office to refuse contributions from tobacco
17 companies and their subsidiaries; and (9) Calls upon all candidates for public office to
18 refuse contributions from any organization that opposes public health measures to
19 reduce firearm violence. (Modify Current HOD Policy)
20

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Gun violence has been a priority for our AMA for many years. Our delegation continues to believe that gun violence is an issue that needs to be addressed with transparency in the United States. Gun Violence in recent years has become a public health emergency as we have seen increase in mass shootings and police involved shootings. It is imperative that AMA takes a stand on this issue and lobby for research to be done on the effects of gun violence. Furthermore, the language of this resolution specifically and intentionally models after the language of existing clause(8).

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RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban. (Res. 1011, A-16, Reaffirmation: A-18, Reaffirmation: I-18)

Political Action Committees and Contributions G-640.020

Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;
(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;
(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;
(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;
(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;
(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;
(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and
(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries. (BOT Rep. II and Res. 119, I-83, Res. 175, A-88, Reaffirmed: Sunset Report, I-98, Sub. Res. 610, A-99, Res. 610, I-00, Consolidated: CLRPD Rep. 3, I-01, Modified: CCB Rep. 2, A-11)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms. (CSA Rep. A, I-87, Reaffirmed: BOT Rep. 50, I-93, Appended: Res. 403, I-99, Reaffirmation: A-07, Reaffirmation: A-13, Appended: Res. 921, I-13, Reaffirmed: CSAPH Rep. 04, A-18, Reaffirmation: A-18, Reaffirmation: I-18, Appended: Res. 405, A-19)

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Sub. Res. 221, A-13, Appended: Res. 416, A-14, Reaffirmed: Res. 426, A-16, Reaffirmed: BOT Rep. 28, A-18, Reaffirmation: A-18, Modified: CSAPH Rep. 4, A-18, Reaffirmation: I-18)

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (CSAPH Rep. 4, A-18, Reaffirmed: BOT Rep. 11, I-18)

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored. (Res. 140, I-87, Reaffirmed: BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmed: CSAPH Rep. 1, A-15, Modified: BOT Rep. 12, A-16, Appended: Res. 433, A-18, Reaffirmation: I-18, Modified: BOT Rep 11, I-18)

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
- (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
- (4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
- (5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths. (BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation A-14, Appended: Res. 427, A-18, Reaffirmation: A-18, Modified: Res. 244, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(JUN-21)

Introduced by: Arizona, Colorado

Subject: Improving the Prior Authorization Process

Referred to: Reference Committee G

1 Whereas, Prior authorization is a recognized factor in the delay of patient care; and

2
3 Whereas, Each insurance company, pharmacy benefit manager and retail pharmacy all have
4 different prior authorization processes which create undue stress and time to complete these
5 processes on physician practices; and

6
7 Whereas, Denials from insurance companies, pharmacy benefit managers, and retail
8 pharmacies do not inform the prescribing physician at the time of the denial of alternative but
9 similar medications which are on the patients formulary; therefore be it

10
11 RESOLVED, That our American Medical Association promote that all medication denials from
12 insurance companies, pharmacy benefit managers or retail pharmacies provide the approved
13 formulary alternatives in the same class of medications or the step edit requirements at the
14 time of the denial to the prescribing physician (Directive to Take Action); and be it further

15
16 RESOLVED, That at the time of denial by insurance companies, pharmacy benefit managers,
17 or retail pharmacies, that our AMA advocate they be required to inform the patient of the
18 lowest cash or discount card price for that medication. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The resolution is timely and should be discussed at the A2021 for the following reasons:

1. Physician burnout, which is at an all-time high during the Covid-19 pandemic, is due in part by the increasingly onerous prior authorization process. The resolution is an attempt to simplify the process for physician practices by forcing the denying pharmacy benefit manager, insurance company, or retail pharmacy to immediately at the time of medication denial to provide the prescriber with formulary alternatives and not force the provider to submit a prior authorization to determine the alternative medications which are on the formulary.
2. Patients deserve to know at the time of purchase of medications that the cash or discount cash price may be lower than the copay required by their insurance. If a medication is denied by insurance, the patient should be provided the cash or discount card price so they may determine if their purchase should not be subject to further insurance company delay due to the prior authorization process.
3. The resolution demands transparency in the prior authorization process to both the patient and physician which is not currently the case. Further delay in consideration of the resolution will cost patients dollars and practices in time and money they both can ill afford.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Prevent Medicare Advantage Plans from Limiting Care

Referred to: Reference Committee G

Whereas, There are Medicare guidelines for most treatments for patients including, but not limited to criteria for admissions, diagnostic testing, medications, and procedures; and

Whereas, Medicare Advantage plans may not consistently follow Medicare guidelines resulting in patients who are insured by Medicare Advantage plans not receiving the same level of treatment as patients insured by standard Medicare; and

Whereas, When asked about denial of services, the Medicare Advantage plans state that Medicare guidelines allow them to approve a service but do not require them to do so; and

Whereas, Medicare Advantage plans often use proprietary criteria (such as Milliman and InterQual) or NaviHealth algorithms to determine eligibility of Medicare beneficiaries for admissions, diagnostic testing, medications, and procedures, which is an additional barrier that limits access to services and is often at odds with the professional judgement of the patient's physician; and

Whereas, Patients who have symptoms consistent with Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") could be denied necessary treatment by the use of proprietary criteria; therefore be it

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and that care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions when the criteria are at odds with the professional judgment of the patient's physician. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution should be included for the June 2021 Special Meeting of the AMA HOD because there are ongoing access to care issues for many Medicare patients who are in high risk categories for poor health outcomes due to the COVID-19 pandemic and those suffering from Long COVID. This affects all physicians who care for Medicare patients. Ensuring equal access to care for all those covered by Medicare and Medicare Advantage (MA) plans is timely and imperative, because all patients deserve equal access to medically necessary care. MA and other private plans account for 40 percent of all Medicare beneficiaries. Other private plans consist of private fee-for-service plans, cost plans, Medicare medical savings account plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid plans participating in CMS's financial alignment demonstration. MA enrollment represents 39 percent of all 62.2 million Medicare beneficiaries (and 42 percent of all 56.5 million beneficiaries enrolled in both Medicare Part A and Part B). Enrollment in MA plans that are paid on an at-risk capitated basis reached 24.0 million enrollees in February 2020. The most recent data for 2021 indicated there was a 13% increase in MA plans compared to 2020, which equates to 3,550 total MA plans¹.

¹ Biniek, J., Freed, M., Damico, A. and Neuman, T., 2020. *Medicare Advantage 2021 Spotlight: First Look*. [online] KFF. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/> [Accessed 11 May 2021].

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(JUN-21)

Introduced by: American College of Rheumatology, American Gastroenterological Association, American Academy of Ophthalmology, American College of Gastroenterology, American Academy of Dermatology, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology

Subject: Financial Incentives for Patients to Switch Treatments

Referred to: Reference Committee G

1 Whereas, All patients should have access to the medications they and their provider feel are
2 most appropriate; and
3

4 Whereas, Biologic drugs are highly effective and have the potential to reduce long-term
5 disability; however, they are not without certain risks. All classes of biologics used in
6 autoimmune diseases may cause serious adverse events. The decision to choose one biologic
7 over another requires careful clinical evaluation and consideration by a physician and patient.
8 Factors such as an individual patient's age, gender, diagnosis, medications, specific organ
9 manifestations, antibody status, disease severity, comorbid conditions, and ability to tolerate the
10 route of administration strongly influence the specific biologic choice; and
11

12 Whereas, Due to these highly individual characteristics among patients, the journey to finding
13 an effective treatment is often long and challenging. The complex medical decision making, and
14 subsequent risks associated with these medications, fall on the physician and the patient, so
15 these decisions should not be curtailed by a health plan's coverage policies; and
16

17 Whereas, In March of 2021, Cigna notified patients that they could be eligible for a \$500 pre-
18 paid medical debit card if they agree to stop taking Cosentyx (secukinumab) and switch to a
19 payer-preferred alternative medication; and
20

21 Whereas, Incentivizing patients who are stable on an effective therapy to abandon treatment for
22 non-medical reasons needlessly puts them at risk for significant long-term consequences
23 including irreversible damage and disability. Patients who are switched to another treatment
24 may experience serious disease flares, as even drugs with similar mechanisms of action have
25 widely variable patient to patient effectiveness; and
26

27 Whereas, Using money to persuade patients to make a choice against their own health raises
28 ethical concerns and is highly irresponsible, especially when so many have suffered financially
29 due to the ongoing pandemic and may be swayed by financial incentive to make a decision
30 contrary to their health interests; and
31

32 Whereas, This initiative jeopardizes patients' health, interferes with medical decision making,
33 and undermines the doctor-patient relationship by possibly obliging physicians to counsel
34 patients to forgo the \$500 payment in order to safeguard their health; and
35

36 Whereas, This program will disproportionately affect patients of lower socio-economic status,
37 who may have less ability to refuse such a payment despite their health interests; and

1 Whereas, Other large national insurers are contemplating adopting or expanding similar policies
2 financially incentivizing patients to switch treatments, and these policies could quickly become
3 common across multiple disease states if not checked; and
4

5 Whereas, It is of the highest urgency during this time of economic uncertainty and public health
6 emergency that payers avoid policies that would take advantage of financial instability and
7 jeopardize patient health; therefore be it
8

9 RESOLVED, That our American Medical Association oppose the practice of insurance
10 companies providing financial incentives for patients to switch treatments (New HOD Policy);
11 and be it further
12

13 RESOLVED, That our AMA support legislation that would ban insurer policies that provide
14 patients financial incentives to switch treatments, and will oppose legislation that would make
15 these practices legal (Directive to Take Action); and be it further
16

17 RESOLVED, That our AMA engage with state regulators urging review of the legality of such
18 policies providing financial incentives to patients who switch to preferred drugs. (Directive to
19 Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Especially during the PHE, ensuring patients stay on their medication is urgent and of the highest priority. However, new tactics by insurance companies to financially incentivize patients who are stable on effective therapy to abandon that treatment for non-medical reasons needlessly put patients at risk.

This year, Cigna notified patients they could receive \$500 debit cards if they agreed to stop taking a non-preferred medication and switch to the payer-preferred alternative. There are indications this policy is planned to be expanded and other large payers including UHC have signaled desires to adopt or expand this type of program. Additionally, at least one piece of state legislation proposed this year would explicitly make these policies legal. Without action in opposition these tactics are likely to proliferate, affecting many physicians and patients.

Payer policies should not interfere with complex medical decisions about treatments. Using monetary incentives to persuade patients to make choices against their own health is particularly irresponsible when so many have suffered financially due to the COVID-19 pandemic, especially patients of lower socio-economic status who may have less ability to refuse a payment despite health interests.

It is of the highest priority during this time of economic uncertainty and public health emergency that payers do not take advantage of financial instability and jeopardize patient health. It is urgent that we have policy in opposition and take action protecting patients' health, medical decision making, and the physician-patient relationship.

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):

- a. Collaborate with the physician community in the development and implementation of patient incentives.
- b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
- c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
- d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
- e. Provide referring and/or primary care physicians with the full record of the service encounter.
- f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
- g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.

2. Our AMA supports the following quality and cost principles for any FIP:

- a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
- b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
- c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
- d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
- e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
- f. Provide meaningful transparency of prices and vendors.
- g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
- h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
- i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.

3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.

4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.

6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:

- a. Patient outcomes/the quality of care provided with shopped services;
- b. Patient utilization of shopped services;
- c. Patient satisfaction with care for shopped services;
- d. Patient choice of health care provider;
- e. Impact on physician administrative burden; and
- f. Overall/systemic impact on health care costs and care fragmentation.

CMS Rep. 2, I-19

E-9.6.3 Incentives to Patients for Referrals

Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.

Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.

AMA Principles of Medical Ethics: I,II,VIII

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(JUN-21)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee G

Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled, nor any limits to number or repetitiveness of these requests; and

Whereas, Complying with these records requests can require extensive staff time and other associated costs; and

Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time involved in complying with these requests; and

Whereas, Each Medicare Advantage plan has different rules for record requests governed by the contract between the plan and provider; therefore be it

RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has created substantial financial issues for physician practices due to reductions in elective procedures and challenges maintaining appropriate staffing. Requests from Medicare Advantage plans for medical records have been a consistent issue that requires extensive staff time and may be costly for the practice to complete. Limiting these requests will help already stressed practices as they recover after the pandemic subsides. Finding solutions to the financial pressures facing practices right now cannot wait if the health care system in the United States is to adequately recover from the pandemic. The AMA's current policy does not include a specific maximum amount of records that plans should be authorized to request. Due to the national nature of Medicare Advantage plans, the AMA is in the best position to advocate for these changes and advocating for the relief of administrative burdens is an important component of promoting the art and science of medicine.

RELEVANT AMA POLICY

Limiting Access to Medical Records H-315.987

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.

Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16