

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 19, 2022

Subject: Handbook Addendum - Supplemental Business and Information

We are pleased to provide the attached report and resolutions that were received after the initial Delegates' Handbook was published and by the on time deadline.:

Report of the HOD Committee on Compensation of the Officers

- Report of the House of Delegates Committee on the Compensation of the Officers (Reference Committee F)

Resolutions

- 014 Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population
- 015 Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women
- 016 Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border
- 017 Humanitarian and Medical Aid Support to Ukraine
- 018 Hardship for International Medical Graduates from Russia and Belarus
- 019 Hardship for International Medical Graduates from Ukraine
- 020 Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals
- 021 National Cancer Research Patient Identifier
- 022 Organ Transplant Equity for Persons with Disabilities
- 023 Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options
- 024 Pharmaceutical Equity for Pediatric Populations
- 025 Use of Social Media for Product Promotion and Compensation
- 126 Providing Recommended Vaccines Under Medicare Parts B and C
- 127 Continuity of Care Upon Release from Correctional Systems
- 221 Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level
- 222 To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
- 223 National Drug Shortages of Lidocaine and Saline Preparations
- 224 HPSA and MUA Designation for SNFs
- 225 Public Listing of Medical Directors for Nursing Facilities
- 226 Coverage for Clinical Trial Ancillary Costs
- 227 Supporting Improvements to Patient Data Privacy
- 228 Expanded Child Tax Credit

- 229 Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
- 230 Advancing the Role of Outdoor Recreation in Public Health
- 231 Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
- 232 Expansion of Epinephrine Entity Stocking Legislation
- 233 Support for Warning Labels on Firearm Ammunition Packaging
- 234 Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities
- 235 Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System
- 236 Out-of-Network Care
- 237 Prescription Drug Dispensing Policies
- 238 COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
- 239 Virtual Services When Patients Are Away From Their Medical Home
- 240 Physician Payment Reform and Equity
- 241 Unmatched Graduate Physician Workforce
- 242 Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System
- 243 Appropriate Physician Payment for Office-Based Services
- 244 Prohibit Reversal of Prior Authorization
- 318 CME for Preceptorship
- 319 Senior Living Community Training for Medical Students and Residents
- 320 Tuition Cost Transparency
- 321 Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations
- 322 Standards in Cultural Humility Training Within Medical Education
- 323 Cultural Leave for American Indian Trainees
- 324 Sexual Harassment Accreditation Standards for Medical Training Programs
- 325 Single Licensing Exam Series for Osteopathic and Allopathic Medical Students
- 326 Standardized Wellness Initiative Reporting
- 327 Leadership Training Must Become an Integral Part of Medical Education
- 328 Increasing Transparency of the Resident Physician Application Process
- 329 Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine
- 420 Declaring Climate Change a Public Health Crisis
- 421 Screening for HPV-Related Anal Cancer
- 422 Voting as a Social Determinant of Health
- 423 Awareness Campaign for 988 National Suicide Prevention Lifeline
- 424 Physician Interventions Addressing Environmental Health and Justice
- 425 Mental Health Crisis
- 426 Mental Health First Aid Training
- 427 Pictorial Health Warnings on Alcoholic Beverages
- 428 Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities
- 429 Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality
- 430 Longitudinal Capacity Building to Address Climate Action and Justice
- 431 Protections for Incarcerated Mothers and Infants in the Perinatal Period
- 432 Recognizing Loneliness as a Public Health Issue
- 433 Support for Democracy
- 434 Support for Pediatric Siblings of Chronically Ill Children
- 435 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

- 436 Training and Reimbursement for Firearm Safety Counseling
- 516 Oppose "Mild Hyperbaric" Facilities from Delivering Unsupported Clinical Treatments
- 517 Safeguard the Public from Widespread Unsafe Use of "Mild Hyperbaric Oxygen Therapy"
- 518 Over-the-Counter Access to Oral Contraceptives
- 519 ARPA-H Advanced Research Projects Agency for Health
- 520 Addressing Informal Milk Sharing
- 521 Encouraging Brain and Other Tissue Donation for Research and Educational Purposes
- 522 Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido
- 523 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
- 524 Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings
- 611 Continuing Equity Education
- 612 Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce
- 613 Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee
- 614 Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office
- 615 Anti-Harassment Training
- 616 Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections
- 617 Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
- 618 Extending the Delegate Apportionment Freeze During COVID-19 Pandemic
- 619 Focus and Priority for the AMA House of Delegates
- 620 Review of Health Insurance Companies and Their Subsidiaries' Business Practices
- 723 Physician Burnout
- 724 Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic
- 725 Compensation to Physicians for Authorizations and Preauthorizations
- 726 Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs
- 727 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

In addition, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the June 2021 and November 2021 Special Meetings will be posted on the June 2022 Annual Meeting website.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report June 2022

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE
COMPENSATION OF THE OFFICERS

Presented by: Steven Tolber, MD, Chair

Referred to: Reference Committee F

1 This report by the committee at the 2022 Annual meeting presents two recommendations.

2
3 BACKGROUND

4
5 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
6 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
7 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
8 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
9 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board, among
10 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker and Vice
11 Speaker of the HOD, collectively referred to in this report as “Officers.” The composition,
12 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
13 under the AMA Bylaws. Bylaw 2.13.4.5 provides:

14
15 The Committee shall present an annual report to the House of Delegates recommending the
16 level of total compensation for the Officers for the following year. The recommendations of the
17 report may be adopted, not adopted, or referred back to the Committee, and may be amended
18 for clarification only with the concurrence of the Committee.

19
20 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
21 definition of total compensation which was added to the Glossary of the AMA Constitution and
22 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
23 individual for work performance, including: (a) all forms of money or cash compensation;
24 (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

25
26 Since the inception of this Committee, its reports document the process the Committee follows to
27 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
28 compensation practices as derived from research and use of independent external consultants,
29 expert in Board compensation. Reports beginning in December 2002 documented the principles the
30 Committee followed in creating its recommendations for Officer compensation.

31
32 At A-08, the HOD approved changes that simplified compensation practices with increased
33 transparency and consistency. At A-10, Reference Committee F requested that this Committee
34 recommend that the HOD affirm a codification of the current compensation principle, which
35 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
36 its recommendations for Officer compensation on the principle of the value of work performed,

1 consistent with IRS guidelines and best practices recommended by the Committee's external
2 independent consultant, who is expert in Board compensation.

3
4 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
5 with that of all other Officers (excluding Presidents and Chair) because these positions perform
6 comparable work.

7
8 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
9 Group, to update his 2007 research by providing the Committee with comprehensive advice and
10 counsel on Officer compensation. The updated compensation structure was presented and approved
11 by the HOD at I-11 with an effective date of July 1, 2012.

12
13 The Committee's I-13 report recommended and the HOD approved the Committee's
14 recommendation to provide a travel allowance for each President to be used for upgrades because
15 of the significant volume of travel representing our AMA.

16
17 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
18 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the
19 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems
20 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the
21 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal
22 Representation, greater than eleven days, receives a per diem.

23
24 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved
25 the Committee's recommendation to increase the President, President-elect, Immediate Past-
26 President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

27
28 At A-18 and A-19, the House approved the Committee's recommendation to provide a Health
29 Insurance stipend to President(s) who are under Medicare eligible age when the President(s) and
30 their covered dependents, not Medicare eligible, lose the President's employer provided health
31 insurance during their term as President. Should the President(s) become Medicare eligible while in
32 office, they received an adjusted Stipend to provide insurance coverage to their dependents not
33 Medicare eligible.

34
35 The Committee's I-19 report recommended and the HOD approved the Committee's
36 recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding
37 Presidents and Chair, by approximately 3% each effective July 1, 2020.

38 39 FINDINGS

40
41 At I-21, this Committee recommended that an upgrade allowance in the amount of \$1250 for all
42 Officers except President, President-elect and Immediate Past President ("Leadership") be piloted
43 between November 17, 2021 through April 17, 2022. Use of the upgrade allowance for Officers
44 would comport with the current definition in the travel policy and the Board travel and expense
45 standing rules. The Committee committed to reporting on the use of the upgrade allowance during
46 the pilot and reports that during the six-month pilot, six Officers used the upgrade allowance in
47 amounts ranging from \$30 - \$616. In addition, Board Representation Office staff reported that
48 Officers were very appreciative of the availability of the upgrade allowance.

49
50 Demand for air travel has risen since the beginning of 2022. NPR (National Public Radio) reported
51 in April 2022 that based on consumer spending demand for travel this past February was 6% higher

1 than in February 2019 and was 18% higher than January 2022. In addition, as of April 18, 2022 the
2 CDC's January 29, 2021 Order requiring masks on public transportation and at transportation hubs
3 was lifted by court order. And as of May 1, the CDC website showed the number of Covid-19
4 cases slowly increasing.

5
6 Our Officers are traveling to represent the AMA while continuing to represent the AMA in
7 podcasts, on webinars, and other media to advocate on behalf of physicians and patients. Based on
8 use of the upgrade allowance during the pilot and feedback from the Officers, and to continue to
9 minimize the risks associated with crowded flights and the ease of transmission of COVID-19, the
10 Committee recommends implementing an upgrade allowance for each Officer, excluding the three
11 Presidents, in the amount of \$2500 per term beginning July 1, 2022. Use of the upgrade allowance
12 will comport with the current definition in the travel and expense standing rules and will be
13 included in the annual report of Officer Compensation presented annually to the House of
14 Delegates.

15
16 The Committee commends and thanks our Officers for their representation of the AMA.

17
18 RECOMMENDATIONS

- 19
20 1. That there be no changes to the Officers' compensation for the period beginning July 1, 2022
21 through June 30, 2023. (Directive to Take Action.)
22
23 2. That the travel policy and the Board travel and expense standing rules be amended by addition,
24 shown with underscores as follows:

25
26 Transportation

- 27 a. Air: AMA policy on reimbursement for domestic air travel for members of the Board is
28 that the AMA will reimburse for coach fare only. The Presidents (President, Immediate
29 Past President and President Elect) will each have access to an individual \$5000 term
30 allowance (July 1 to June 30) and all other Officers will each have access to \$2500 term
31 allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically
32 when traveling on an airline with non-preferred status. The unused portion of the
33 allowance is not subject to carry forward or use by any other Officer and remains the
34 property of the AMA. In rare instances it is recognized that short notice assignments may
35 require up to first class travel because of the lack of availability of coach seating, and this
36 will be authorized when necessary by the Board Chair, prior to travel. Business Class
37 airfare is authorized for foreign travel on AMA business. (Also see Rule IV –Invitations,
38 B—Foreign, for policy on foreign travel). (Directive to Take Action)
39
40 3. That the remainder of the report be filed.

Fiscal Note: Estimated cost for July 1, 2022 – June 30, 2023 is a maximum of \$52,500 if all
Presidents and Officers use the whole allowance.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480
Officers	\$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation I either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is \$700.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-22)

Introduced by: Women Physicians Section

Subject: Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Gender dysphoria is defined as the “discomfort or distress that is caused by a
2 discrepancy between a person’s gender identity and that person’s sex assigned at birth”⁶; and
3

4 Whereas, A 2021 national survey analyzed the experiences of LGBTQ youth and found that
5 “75% experienced discrimination based on their sexual orientation or gender identity,” while
6 “48% reported they wanted counseling...but were unable to receive it this past year”²; and
7

8 Whereas, A longitudinal study of 6327 transgender and gender diverse individuals, found that
9 younger people had 7 times greater risk for suicide attempts underneath the age of 18 years
10 old⁵; and
11

12 Whereas, A study of cisgender and transgender individuals, found that transgender groups
13 experienced “worse mental health” and “higher odds of multiple chronic conditions, poor quality
14 of life, and disabilities than both cisgender males and females”³; and
15

16 Whereas, An article found that “few transgender youth eligible for gender-affirming treatments
17 actually receive them,” with potential barriers spanning from “accessible...providers trained in
18 gender affirming care,” “gatekeeping or uncoordinated care,” “limited or delayed access” to
19 treatments, and “insurance exclusions”⁴; and
20

21 Whereas, Federal Civil Rights Laws such as Section 1557 Patient Protection and Affordable
22 Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, and
23 disability in covered health programs or activities; and
24

25 Whereas, The Supreme Court’s Decision in Bostock and Title IX enforces Section 1557’s
26 prohibition on discrimination on the basis of sex to include: (1) discrimination on the basis of
27 sexual orientation; and (2) discrimination on the basis of gender identity; and
28

29 Whereas, There are “two common approaches to assess an individual before commencing of
30 gender-affirming hormone therapy (GAHT); a mental health practitioner assessment and
31 approval or an informed consent model undertaken with a primary care general practitioner
32 (GP)” and a “sexual health physician or endocrinologist”⁷; and
33

34 Whereas, In gender affirming care, “medical interventions for transition may affect risk profiles
35 for many diseases, including cancer and cardiovascular disease”⁸; and
36

37 Whereas, The American Academy of Family Physicians currently opposes medically
38 unnecessary surgeries in intersex infants, along with the World Health Organization (WHO) and
39 many other intersex-led organizations across the world¹; therefore be it

1 RESOLVED, That our American Medical Association support shared decision making between
 2 gender diverse individuals, their families, their primary care physician, and a multidisciplinary
 3 team of physicians and other health care professionals including, but not limited to, those in
 4 clinical genetics, endocrinology, surgery, and behavioral health, to support informed consent
 5 and patient personal autonomy, increase access to beneficial gender affirming care treatment
 6 options and preventive care, avoid medically unnecessary surgeries, reduce long term patient
 7 dissatisfaction or regret following gender affirming treatments, and protect federal civil rights of
 8 sex, gender identity, and sexual orientation. (New HOD Policy)

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

Received: 05/04/22

References:

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6. Kirouac N, Tan M. Gender Creative or Transgender Youth and Advanced Nursing Practice. Pediatr Endocrinol Rev. 2017 Jun;14(Suppl 2):441-447. doi: 10.17458/per.vol14.2017.kt.gendercreativetransgender. PMID: 28647948.
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RELEVANT AMA POLICY

Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Citation: Res. 003, A-17; Modified: Res. 005, I-18

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; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

Citation: Res. 05, A-16; Modified: Res. 015, A-21

Affirming the Medical Spectrum of Gender H-65.962

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Citation: Res. 005, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-22)

Introduced by: Women Physicians Section

Subject: Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The United Nations High Commissioner for Refugees designated refugee women as
2 a high-risk group for developing serious psychological problems due to their premigration war
3 experiences of rape and sexual violence¹; and
4

5 Whereas, One in five women refugees experience sexual violence. 50% of refugees, internally
6 displaced or stateless populations, are women and girls²; and
7

8 Whereas, In the resettlement country, refugee women not only have to cope with their
9 premigration traumas, but also they encounter significant challenges in postmigration
10 adjustment such as adapting to a new culture, a change in SES, and unemployment³; and
11

12 Whereas, Refugee women play a crucial role in the lives of family members; what affects the
13 women directly impacts their families; and
14

15 Whereas, One in five (22.1%) of the adult population in conflict-affected areas have mental
16 health problems⁵; and
17

18 Whereas, There has been a lack of procedural or financial support for mental health screening
19 for refugees⁶; and
20

21 Whereas, State refugee health coordinators surveyed in 2010 reported that only 4 of the 44
22 states surveyed used a formal screening instrument and 68% used informal conversation⁷; and
23

24 Whereas, Several well-utilized tools having a number of drawbacks such as not being validated
25 in forced migration populations (8.1, 8.2), too prolonged to facilitate rapid screening of large
26 populations (8.3), screening for distress rather than disorder (8.3), lacking predictive validity
27 against a standardized psychiatric interview (8.3), and screening for either major depressive
28 disorder or PTSD – not both (8.4, 8.5)⁸; and
29

30 Whereas, A recent review raised concerns about the lack of evidence for the validity and
31 cultural equivalence of the K10 (Kessler Psychological Distress Scale), including variation
32 between ethnic/linguistic groups for studies with multicultural samples⁹; and
33

34 Whereas, The Self Reporting Questionnaire-20 was developed to screen for psychiatric
35 disturbance, but primarily for those in developing countries, and has not established its
36 predictive validity against a standardized psychiatric interview¹⁰; and

Whereas, The Refugee Health Screener-15 was developed for refugee populations, it was designed to be administered in clinical settings, and has not been validated in asylum-seeker populations or against an acceptable gold standard¹¹; and

Whereas, There is an ongoing refugee crisis, where refugees have been displaced over the years by war in Iraq, Yemen, Syria, Palestine, Myanmar, Congo, Somalia, and more recently, Afghanistan and Ukraine; and

Whereas, It is critical that counselors are aware, understand, and accept the influence of culture on the conceptualization of mental health and patterns of symptom presentation; and

Whereas, There is a building and unaddressed mental health crisis being, refugee women could generate and contribute 1.4 trillion to the annual global GDP¹²; therefore be it

RESOLVED, That our American Medical Association advocate for increased research funding to create rapid, accessible, and patient centered mental health screening tools pertaining to refugee and migrant populations (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased funding to the National Institutes of Health for more research on evidence-based designs on delivery of mental health services to refugees and migrant populations (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased mental health funding to increase the number of trained mental health providers to carry out mental health screenings and treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for and encourage culturally responsive mental health counseling specifically. (Directive to Take Action)

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

Received: 05/04/22

References:

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- <https://www.unhcr.org/en-us/figures-at-a-glance.html>, <https://www.unhcr.org/flagship-reports/globaltrends/>
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- <https://refugeehealthta.org/physical-mental-health/mental-health/adult-mental-health/screening-for-emotional-distress-and-mental-health/#~:text=The%20Office%20of%20Refugee%20Resettlement,mental%20health%20screening%20for%20refugees>
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- <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-2021#refugee-arrivals-countries-origin>
- <https://www.rescue.org/press-release/new-report-refugee-women-could-generate-14-trillion-annual-global-gdp#:~:text=According%20to%20a%20new%20analysis,and%20wage%20gaps%20were%20closed>
- <https://www.womenforwomen.org/blogs/5-facts-about-what-refugee-women-face>

RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(A-22)

Introduced by: Women Physicians Section

Subject: Addressing and Banning Unjust and Invasive Medical Procedures Among
Migrant Women at the Border

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, In October 2020, at least 57 women in a Georgia Immigration and Customs
2 Enforcement detention center said they were forced or pressured into having gynecological
3 procedures¹; and
4

5 Whereas, Women stated they were threatened with retaliation if they pushed back on
6 recommended procedures, even in cases where their original complaints were non-
7 gynecological²; and
8

9 Whereas, As of December 2020, 40 more women had submitted claims of abuse and unwanted
10 invasive medical procedures³; and
11

12 Whereas, There has been no follow up since it was first reported in 2020 and since the
13 members of Congress asked for it to be further investigated in 2021⁴; and
14

15 Whereas, It is important that the AMA recognize these atrocious crimes and stand firmly against
16 them; therefore be it
17

18 RESOLVED, That our American Medical Association condemn the performance of
19 nonconsensual, unnecessary, invasive medical procedures (Directive to Take Action); and
20

21 RESOLVED, That our AMA advocate against forced sterilizations of any kind, including against
22 migrant women in detention facilities, and advocate for appropriate associated disciplinary
23 action (including license revocation) (Directive to Take Action); and
24

25 RESOLVED, That our AMA advocate for safer medical practices and protections for migrant
26 women. (Directive to Take Action)

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

Received: 05/04/22

References:

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2. <https://www.proquest.com/openview/10e623a1a27dee0d92080671a61c060b/1?pq-origsite=gscholar&cbl=2043523>
3. <https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html>
4. <https://time.com/6049998/ice-end-use-detention-centers-georgia-detention-hysterectomy-allegations/>
5. <https://www.theguardian.com/us-news/2020/dec/22/ice-gynecologist-hysterectomies-georgia>
6. <https://homeland.house.gov/news/press-releases/homeland-security-and-oversight-committees-release-update-on-georgia-ice-facility-investigation-inquire-on-dhs-action-to-protect-migrants>

RELEVANT AMA POLICY

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.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

Citation: Res. 002, A-17; Appended: Res. 218, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(A-22)

Introduced by: International Medical Graduate Section

Subject: Humanitarian and Medical Aid Support to Ukraine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Ukraine has been senselessly invaded by Russia on February 24th, 2022, which
2 resulted in a full-blown war operation involving countless attacks on civilians; and
3

4 Whereas, After a month of war, there have already been 10 million refugees from Ukraine with
5 nearly half of Ukrainian families being separated, including children, people with special needs,
6 victims of war trauma; and
7

8 Whereas, There are war-induced adversities affecting children that include but not limited to
9 physical and/or mental health risks related to forced family separation, loss of access to school
10 and healthcare, insecure access to food and shelter, and displacement from homes and
11 communities; and
12

13 Whereas, War-related events cause significant mental health issues, particularly, depressive
14 symptomatology among mothers further negatively affecting wellbeing of both mothers and their
15 children; and
16

17 Whereas, Multiple medical organizations from the U.S. and worldwide denounced the war and
18 provided help to the Ukrainian people such as medical team trips, medical equipment, financial
19 aid, acceptance of those in need of care; and
20

21 Whereas, The AMA denounced the war, joined the World Medical Association and other
22 medical societies in calling for an end to this war; and
23

24 Whereas, The AMA Foundation created a fund to support the humanitarian crisis in Ukraine;
25 therefore be it
26

27 RESOLVED, That our American Medical Association advocate for continuous support of
28 organizations providing humanitarian missions and medical care to Ukrainian refugees in
29 Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (Directive to Take
30 Action) and be it further
31

32 RESOLVED, That our AMA advocate for an early implementation of mental health measures
33 and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian
34 refugees with special attention to vulnerable populations including but not limited to young
35 children, mothers, and pregnant women (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA advocate for educational measures to enhance the understanding
38 of war-related trauma in war survivors and promote efforts to increase resilience in war-affected
39 people targeting vulnerable categories of people. (Directive to Take Action)

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

Received: 05/04/22

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1. Szewczyk, B. M. J. (2022, March 25). There Could Be 10 Million Ukrainian Refugees Fleeing Putin's Bombs. Foreign Policy. <https://foreignpolicy.com/2022/03/04/ukraine-russia-war-refugees-10-million/>
2. Kwai, I. (2022, March 8). W.H.O. Condemns Attacks on Health Care Services in Ukraine, Calls for Safe Passage for Medical Supplies. The New York Times. <https://www.nytimes.com/2022/03/08/world/europe/health-service-attacks-ukraine-who.html>
3. Morgan, J. (2022, March 10). Global medical and public health organizations call for immediate end to war in Ukraine and critical need to prevent nuclear escalation. Physicians for Social Responsibility. <https://www.psr.org/blog/global-medical-and-public-health-organizations-call-for-immediate-end-to-war-in-ukraine-and-critical-need-to-prevent-nuclear-escalation/>
4. American Medical Association. (2022, March 22). Senseless war in Ukraine sparks physician aid response. <https://www.ama-assn.org/delivering-care/population-care/senseless-war-ukraine-sparks-physician-aid-response>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-22)

Introduced by: International Medical Graduate Section

Subject: Hardship for International Medical Graduates from Russia and Belarus

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Russia, with the support of Belarus, invaded Ukraine on February 24, 2022, causing the international community to respond with sanctions and having most international businesses to leave both countries due to oppressors; and

Whereas, Currently there is nearly absent communication (mail, internet, ability to make payments) with organizations located in Belarus and Russia due to either sanctions or services no longer available; and

Whereas, There are international medical graduates (IMGs) in the U.S. who completed their medical school in Russia or Belarus, and who may require primary source verification for licensure or other certifications/credentialing; and

Whereas, There is a concern that the IMGs from Russia and Belarus, who either are in residency/fellowship training or already practicing, may not be able to obtain primary source verification until the means of communication and relationships are restored; therefore be it

RESOLVED, That our American Medical Association study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting.
(Directive to Take Action)

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

Received: 05/04/22

References:

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2. Linns Stamp News. (2022). USPS temporarily suspends mail service to Russia. Linns Stamp News. <https://www.linns.com/news/postal-updates/usps-temporarily-suspends-mail-service-to-russia>
3. Gil, M. (2022, March 16). What do Russian sanctions mean for my money transfers? Mozo. <https://mozo.com.au/international-money-transfer/articles/what-do-russian-sanctions-mean-for-my-money-transfers>
4. Mihalcik, C. (2022, March 25). These Companies Have Left Russia: The List Across Tech, Entertainment, Finance. CNET. <https://www.cnet.com/news/politics/what-companies-have-left-russia-see-the-list-across-tech-entertainment-and-financial-institutions/>
5. Satariano, A., & Hopkins, V. (2022, March 8). Russia, Blocked From the Global Internet, Plunges Into Digital Isolation. The New York Times. <https://www.nytimes.com/2022/03/07/technology/russia-ukraine-internet-isolation.html>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(A-22)

Introduced by: International Medical Graduate Section

Subject: Hardship for International Medical Graduates from Ukraine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Ukraine is in the midst of a major humanitarian and medical crisis since the Russian
2 invasion on February, 24th, 2022; and
3

4 Whereas, Numerous civilians including children have been killed and millions of Ukrainians
5 have been displaced from their home seeking safety; and
6

7 Whereas, Physicians who went to medical school in Ukraine have no possible means of
8 obtaining primary source verification of medical education; and
9

10 Whereas, Many states require additional verification for IMGs from medical schools, despite the
11 Federation Credentials Verification Services profile, to issue them state medical license; and
12

13 Whereas, Nationwide physicians crisis during the pandemic highlighted the need for multiple
14 state licenses for physicians to serve the underserved areas; therefore be it
15

16 RESOLVED, That our American Medical Association advocate with relevant stakeholders that
17 advise state medical boards to grant hardship waiver for primary source verification of medical
18 education for all licensing requirements for physicians who graduated from medical schools in
19 Ukraine until the current humanitarian crisis in Ukraine is resolved. (Directive to Take Action)

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

Received: 05/04/22

References:

1. Simon, M. F., Timsit, A., & Jeong, A. (2022, March 17). At least 43 attacks on health-care facilities and patients in Ukraine, WHO says. Washington Post. <https://www.washingtonpost.com/world/2022/03/17/ukraine-attacks-hospitals-clinics-health-care-russia/>
2. Reed, B. J. (2022, March 26). Ukraine war: WHO says attacks on health facilities are rising daily. BBC News. <https://www.bbc.com/news/health-60866669>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(A-22)

Introduced by: International Medical Graduate Section

Subject: Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Medical ethics require physicians to treat every patient regardless of race, color,
2 ethnicity, or gender as well as disease itself; and
3

4 Whereas, AMA's Council on Ethical and Judicial Affairs (CEJA) guidelines do address ethical
5 guidelines in case of a pandemic, but they fail to address the current pandemic (COVID)
6 effectively; and
7

8 Whereas, Many physicians have been infected with the corona virus and some have died during
9 care of infected patients; and
10

11 Whereas, Only about 65% of the US population has been vaccinated for COVID-19. Many of
12 the minority populations have not been vaccinated at the same rate as whites; and
13

14 Whereas, Both vaccinated and non-vaccinated individuals can get reinfected and transmit
15 COVID-19; and
16

17 Whereas, The *Wall Street Journal* reported many physicians in several states have refused to
18 provide care to unvaccinated individuals in outpatient settings even with use of PPE; and
19

20 Whereas, CEJA guidelines are the benchmark for medical ethics for most of the healthcare
21 institutions; therefore be it
22

23 RESOLVED, That our American Medical Association and the Council on Ethical and Judicial
24 Affairs issue new ethical guidelines for medical professionals for care of individuals who have
25 not been vaccinated for COVID-19. (Directive to Take Action)

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

Received: 05/04/22

References:

Wallstreet Journal, "Is It Ethical for Doctors to Refuse to Treat Unvaccinated Patients?"; February 14, 2022;
<https://www.wsj.com/articles/doctor-physician-medical-ethics-covid-patient-unvaccinated-hiv-aids-11644852938>

RELEVANT AMA POLICY**An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921**

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.

Citation: Res. 408, I-20; Reaffirmed: Res. 228, A-21; Reaffirmed: Res. 421, A-21; Appended: Res. 408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-22)

Introduced by: Mississippi

Subject: National Cancer Research Patient Identifier

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, In the United States, too often critical information needed by medical researchers to
2 improve the safety and effectiveness of medical treatment is distributed in fragments across
3 large databases. To protect patient privacy, these data elements reside in databases stripped of
4 patient identifying information (PII) making it extremely difficult to consistently reassemble the
5 fragments back into a complete picture for research; and
6

7 Whereas, At the time patients present for care, identifying information (e.g. name, date of birth,
8 social security number if available, etc.) could be transformed into a privacy ensuring National
9 Cancer Registry Identifier (NCRI) using novel cryptographic solution (patent pending) that
10 includes a combination of established techniques (hash functions, blinding functions, single use
11 transactional tokens); and
12

13 Whereas, Creating a privacy-ensuring, unique cancer research identifier could travel with the
14 anonymous fragments of medical information currently collected by large databases, and
15 therefore allow the fragments to be reunited into a complete, yet anonymous cancer journey that
16 researchers can study to improve care; and
17

18 Whereas, The proposed initiative would build on existing data-transfer relationships between
19 health care facilities and quality improvement databases. For example, as medical facilities
20 submit information to various databases (e.g. Medicare, National Cancer Database, Society of
21 Thoracic Surgeons Database, etc.) as part of current workflow, the NCRI would remain
22 associated with the transferred medical information (but PII would not leave the health care
23 entity); and
24

25 Whereas, Requests for data could be handled by a separate entity serving as the honest broker
26 that would curate, link, and distribute the data in compliance with state and federal data use
27 agreements; and
28

29 Whereas, Nearly half of the 1.8 million cancer patients diagnosed each year in the U.S. will
30 have their lives shortened by cancer, highlighting the ongoing urgent need for cancer research
31 which is felt by the public, the medical community, and policymakers; and
32

33 Whereas, Prospective clinical trials are considered the gold-standard for cancer research, and
34 advances from trials have transformed cancer care. However, clinical trials typically require
35 more than 5 years and several million dollars to conduct; and
36

37 Whereas, There is simply not enough time or money to test all of the important aspects of
38 cancer care. The NCRI will dramatically increase the speed and power of real-world research;
39 and

1 Whereas, A nonprofit entity could be established to oversee the NCRI process including
2 managing grant funding, subcontracting to private entities to oversee specific functions (e.g. the
3 identifier workflow, and data curation and research distribution), privacy assurance, security,
4 and compliance. The nonprofit entity would engage federal policy makers, cancer organizations,
5 patient advocacy groups and the data science community for support, access and authorization
6 to move forward; therefore be it

7
8 RESOLVED, That in order to increase the power of medical research, our American Medical
9 Association propose a novel approach to linking medical information while still maintaining
10 patient confidentiality through the creation of a National Cancer Research Identifier (NCRI)
11 (Directive to Take Action); and be it further

12
13 RESOLVED, That our AMA encourage the formation of an organization or organizations to
14 oversee the NCRI process, specific functions, and engagement of interested parties to improve
15 care for patients with cancer. (Directive to Take Action)

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

Received: 05/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(A-22)

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^{1,2}, despite federal
3 and local guidelines which protect against discrimination on the basis of disability³; 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 disabilities⁴ as is applied to the organ transplant
8 process²; 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 evaluation⁵; 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 transplant⁶; 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 services⁷, and patients report feeling that physicians generally have little
23 understanding of living with a disability⁵; 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 successful⁸ and making assumptions regarding post-transplant quality of life for people
28 with IDD violates AMA ethics⁹; 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.A¹¹; 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 disabilities³; and

Whereas, Section 504 of the Rehabilitation Act of 1973 prohibits federally funded programs including hospitals from denying qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits, denying access to programs, services, benefits or opportunities to participate as a result of physical barriers, and denying employment opportunities they are otherwise entitled or qualified⁴; and

Whereas, Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities and ensures physical access for individuals with disabilities to healthcare facilities and appropriate communication technology to assist persons who are visually or hearing impaired¹²; therefore be it

RESOLVED, That our American Medical Association support equitable inclusion of people with Intellectual and Developmental Disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further

RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further

RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action)

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

Received: 05/06/22

References:

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2. Americans with Disabilities Act of 1990, AS AMENDED with ADA Amendments Act of 2008. Accessed July 12, 2020. <https://www.ada.gov/pubs/adastatute08.htm#12102>
3. Section 508 of the Rehabilitation Act. Federal Communications Commission. Published March 1, 2013. Accessed July 12, 2020. <https://www.fcc.gov/general/section-508-rehabilitation-act> Oakbrook Terrace, IL:
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10. Organ Procurement and Transplantation Network Policies. (2020). https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf
11. Section 1557 of the Patient Protection and Affordable Care Act. Relevant RFS & AMA Policy: Medical Care of Persons with Developmental Disabilities H-90.968 6.2.2 Directed Donation of Organs for Transplantation Tissue and Organ Donation H-370.983

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 023
(A-22)

Introduced by: Oregon

Subject: Promoting and Ensuring Safe, High Quality, and Affordable Elder Care
Through Examining and Advocating for Better Regulation of and Alternatives
to the Current, Growing For-Profit Long Term Care Options

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The U.S. population is aging and more than half of adults 65 and older will need long
2 term services and supports (LTSS) including hired in-home caregiving or residential care, and
3 the population receiving these services usually have limited affordable choices available to meet
4 their needs; and

5
6 Whereas, The long term and post acute care industry serves this vulnerable population, and
7 currently approximately 70% of all long term care (LTC) facilities in the US market are for-profit.
8 For-profit facilities operate as profit maximizers by preferring private-pay and Medicare over
9 Medicaid residents and reducing staffing levels to cut costs and perform better financially, thus
10 demonstrating that the responsibility of for-profit companies to maximize profits can be in direct
11 conflict with caring for the neediest and with safest approaches to delivery of care; and

12
13 Whereas, For-profit and private equity companies managing LTC facilities in addition to
14 maintaining lower staff-to-resident ratios have been found to have higher rates of deficiencies
15 (violations of federal quality standards) and serious deficiencies (where harm or jeopardy to a
16 resident occurred), may increase both resident death rates and costs for government payers
17 (11), and may also have business disincentives to invest in facility safety updates (e.g. related
18 to earthquake and flooding risk, communicable disease transmission, extreme weather events,
19 structural maintenance, etc.), placing residents at increased risk especially in the setting of
20 increasingly frequent climate-change-related events; and

21
22 Whereas, Not-for-profit and government LTC facilities generally have higher staff-to-resident
23 and RN-to-resident ratios, which are associated with positive outcomes including “fewer
24 pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of
25 daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care;
26 less improper and overuse of antipsychotics; and lower mortality rates” as well as reduced ED
27 visits and hospital readmissions; and

28
29 Whereas, LTC facilities with lower Medicare five-star ratings demonstrated a higher probability
30 of having COVID-19 cases early in the pandemic, LTC facilities with lower registered nurse
31 staffing had greater numbers of COVID-19 cases and deaths (19), for-profit LTC facilities were
32 noted to have 60% more cases and deaths than not-for-profit facilities, and deaths tied to long
33 term care facilities account for more than a third of American deaths from COVID-19 in 2019
34 and 2020; therefore be it

1 RESOLVED, That our American Medical Association advocate for business models in long term
 2 care for the elderly which incentivize and promote the ethical use of resources to maximize care
 3 quality, staff and resident safety, and resident quality of life, and which hold patients' interests
 4 as paramount over maximizing profit (Directive to Take Action); and be it further

5
 6 RESOLVED, That our AMA, in collaboration with other stakeholders, advocate for further
 7 research into alternatives to current options for long term care to promote the highest quality
 8 and value long term care services and supports (LTSS) models as well as functions and
 9 structures which best support these models for care. (Directive to Take Action)

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

Received: 05/11/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 024
(A-22)

Introduced by: Michigan

Subject: Pharmaceutical Equity for Pediatric Populations

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Legislation has aimed to increase the quality of evidence from clinical trials in
2 children, 50 percent of pediatric drugs and an even greater portion of neonatal drugs are used
3 "off-label;" and
4

5 Whereas, There are significant discrepancies between the number of drugs developed and
6 approved for use in children compared to adults; and
7

8 Whereas, The average start-up time for pediatric drug trials is 12-16 months compared to six
9 months for adult drug trials and the average duration of a pediatric drug trial is 15 years
10 compared to 8-10 years in adult trials; and
11

12 Whereas, There is an average lag time of 5-10 years between a drug's approval for adults and
13 the addition of pediatric-specific labeling information; and
14

15 Whereas, 60 percent of pediatric drug trials stall and 40 percent of pediatric drug trials fail; and
16

17 Whereas, Historically off-label prescribing has had harmful effects on children, such as
18 Verapamil causing hypotension and death, or Chloramphenicol causing circulatory collapse,
19 also known as "gray baby syndrome;" and
20

21 Whereas, The Pediatric Research Equity Act and Best Pharmaceuticals Act for Children are
22 designed to protect children; and
23

24 Whereas, The exemption of necessitating pediatric trials for "orphan drugs," which are those
25 indicated for the treatment of diseases that affect fewer than 200,000 individuals, creates a
26 loophole for pharmaceutical companies that compromises the quantity and safety of available
27 drugs that can be used in children; and
28

29 Whereas, The Institutional Review Board (IRB) is generally unlikely to approve clinical trials
30 involving children if the drug of interest can be tested on adults; however, the physiologic
31 differences between these groups can have a significant impact on pharmacokinetics and
32 pharmacodynamics; and
33

34 Whereas, Extrapolating efficacy from adult to pediatric populations can streamline pediatric drug
35 development and help to increase the number of approvals for pediatric use, implicit
36 extrapolation of data (i.e. off-label use, without investigation) can have harmful effects on
37 children; and

1 Whereas, The Institute for Advanced Clinical Trials (I-ACT) for Children is an independent
2 501(c)(3) public-private collaboration, funded by membership, a Food and Drug Administration
3 (FDA) U18 grant, and donations that is dedicated to improving the efficiency and success of
4 pediatric drug trials, leading to the development of innovative therapeutic solutions and
5 improvement in the health outcomes of children; and
6

7 Whereas, I-ACT for Children improves pharmaceutical equity for children by connecting
8 pediatric experts, sites, and other resources needed to conduct efficient clinical trials to clinical
9 trial sponsors and stakeholders; and
10

11 Whereas, In 2020, I-ACT for Children was able to design an adaptive platform trial for
12 Duchenne Muscular Dystrophy allowing multiple potential drugs to be tested in parallel,
13 advocated for the inclusion of adolescents in adult clinical trials and planned pediatric studies
14 targeting development of COVID-19 vaccination and treatment; and
15

16 Whereas, I-ACT for Children holds collaboration agreements with sites across the United
17 States, Central and South America, Saudi Arabia, South Africa, Australia, Europe, Canada, and
18 Japan allowing for expansive patient recruitment so that trials can reach enrollment goals faster,
19 accelerating study startup; and
20

21 Whereas, Our AMA already supports policies regarding FDA surveillance of clinical trials to
22 maintain proportional representation of women and minority groups, including consideration of
23 pediatric and elderly populations; therefore be it
24

25 RESOLVED, That our American Medical Association amend Policy H-100.987, "Insufficient
26 Testing of Pharmaceutical Agents in Children," by addition to read as follows:
27

28 Insufficient Testing of Pharmaceutical Agents in Children H-100.987

- 29 1. The AMA supports the FDA's efforts to encourage the development and testing of
30 drugs in the pediatric age groups in which they are used.
31 2. The AMA supports collaboration between stakeholders, including but not limited
32 to the FDA, the American Academy of Pediatrics, and nonprofit organizations
33 such as the Institute for Advanced Clinical Trials for Children, to improve the
34 efficiency and safety of pediatric pharmaceutical trials in pursuit of pharmaceutical
35 equity for pediatric populations. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY**Insufficient Testing of Pharmaceutical Agents in Children H-100.987**

The AMA supports the FDA's efforts to encourage the development and testing of drugs in the pediatric age groups in which they are used.

Citation: Sub. Res. 17, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 025
(A-22)

Introduced by: Medical Student Section

Subject: Use of Social Media for Product Promotion and Compensation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Social media usage in the United States has increased with 81% of adults having a
2 social media profile in 2017¹; and
3

4 Whereas, Consumers cite physician posts and blogs as credible sources of health-related
5 information emphasizing the inherent trust that exists between a patient and a physician, even if
6 that physician is not the consumer's primary care provider¹; and
7

8 Whereas, Social media "influencers" are online personalities with accounts on several social
9 media platforms including, but not limited to, Instagram, Snapchat, TikTok, YouTube, and
10 Facebook, that have influence over their large numbers of followers²; and
11

12 Whereas, Social media marketing, or "influencer marketing" has been cited to be the second
13 most effective promotional strategy as compared to other forms of marketing; this allows many
14 medical social media "influencers" to have an online presence reaching more consumers than a
15 physician in a typical office setting or personal social media account³; and
16

17 Whereas, Physicians active on social media platforms may encounter conflicts of interests as
18 companies, on average, offer Instagram "influencers" with 1,000-10,000 followers \$114 for
19 posting a video and an influencer with 1 million followers up to \$7,000 per post for product
20 promotion⁴; and
21

22 Whereas, The Physician Payments Sunshine Act (PPSA) legally requires medical product
23 manufacturers to report payments or transfers of value to physicians in order to increase
24 transparency and accountability in physicians and the receipt of such payments may diminish
25 the trust the public has in the healthcare system and physicians⁵; and
26

27 Whereas, The American College of Physicians Ethics Manual states, "Physicians should fully
28 disclose their financial interests in selling ethically acceptable products and inform patients
29 about alternatives for purchasing the product"⁶; and
30

31 Whereas, Products promoted by physicians in the media may not be backed by research and
32 have the potential to cause harm to the public through their inefficacy, therefore seeding
33 mistrust in the medical profession^{7,8}; and
34

35 Whereas, The Federal Trade Commission has released guidelines for social media "influencers"
36 on how and when to disclose that videos and posts are sponsored in order to "comply with laws
37 against deceptive ads" and to increase transparency to their audience; and

Whereas, Healthcare workers have been disciplined for social media content and usage including but not limited to, the promotion of products for a company in which they were an authorized representative⁹⁻¹¹; therefore be it

RESOLVED, That our American Medical Association study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

D-105.995 Protecting Social Media Users by Updating FDA Guidelines

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

Res. 209, I-15

3.1.5 Professionalism in Relationships with Media

Ensuring that the public is informed promptly and accurately about medical issues is a valuable objective. However, media requests for information about patients can pose concerns about patient privacy and confidentiality, among other issues.

Physicians who speak on health-related matters on behalf of organizations should be aware of to institutional guidelines for communicating with media, where they exist. To safeguard patient interests when working with representative of the media, all physicians should:

- (a) Obtain consent from the patient or the patient's authorized representative before releasing information.
- (b) Release only information specifically authorized by the patient or patient's representative or that is part of the public record.

(c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician.

(d) Refer any questions regarding criminal activities or other police matters to the proper authorities

AMA Principles of Medical Ethics: IV

Identification of Physicians by the Media H-485.991

It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary he or she be specifically identified with the appropriate initials "MD" or "DO" after his or her name; and that others be identified with the appropriate degrees after their names.

Res. 601, I-01; Reaffirmation I-09; Reaffirmed: BOT Rep. 09, A-19

Ethical Physician Conduct in the Media D-140.957

1. Our AMA will study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform.

2. Our AMA will release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

Res. 16, A-15; Modified: CEJA Rep. 02, I-17

8.11 Health Promotion and Preventive Care

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.

(b) Educate patients about relevant modifiable risk factors.

(c) Recommend and encourage patients to have appropriate vaccinations and screenings.

(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.

(e) Collaborate with the patient to develop recommendations that are most likely to be effective.

(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.

(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

(h) Recognize that modeling health behaviors can help patients make changes in their own lives. Collectively, physicians should:

(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.

(j) Advocate for healthier schools, workplaces and communities.

(k) Create or promote healthier work and training environments for physicians.

(l) Advocate for community resources designed to promote health and provide access to preventive services.

(m) Support research to improve the evidence for disease prevention and health promotion.

AMA Principles of Medical Ethics: V,VII, Issued 2016

Code of Medical Ethics Opinion 9.6.4 Sale of Health-Related Products

The sale of health-related products by physicians can offer convenience for patients, but can also pose ethical challenges. "Health-related products" are any products other than prescription items that, according to the manufacturer or distributor, benefit health. "Selling" refers to dispensing items from the physician's office or website in exchange for money or endorsing a product that the patient may order or purchase elsewhere that results in remuneration for the physician.

Physician sale of health-related products raises ethical concerns about financial conflict of interest, risks placing undue pressure on the patient, threatens to erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the profession of medicine.

Physicians who choose to sell health-related products from their offices or through their office website or other online venues have ethical obligations to:

(a) Offer only products whose claims of benefit are based on peer-reviewed literature or other sources of scientific review of efficacy that are unbiased, sound, systematic, and reliable. Physicians should not offer products whose claims to benefit lack scientific validity.

(b) Address conflict of interest and possible exploitation of patients by:

1. Fully disclosing the nature of their financial interest in the sale of the product(s), either in person or through written notification, and informing patients of the availability of the product or other equivalent products elsewhere.

2. Limiting sales to products that serve immediate and pressing needs of their patients (e.g., to avoid requiring a patient on crutches to travel to a local pharmacy to purchase the product).

Distributing products free of charge or at cost makes products readily available and helps to eliminate the elements of personal gain and financial conflict of interest that may interfere, or appear to interfere with the physician's independent medical judgment.

(c) Provide information about the risks, benefits, and limits of scientific knowledge regarding the products in language that is understandable to patients.

(d) Avoid exclusive distributorship arrangements that make the products available only through physician offices. Physicians should encourage manufacturers to make products widely accessible to patients.

AMA Principles of Medical Ethics: II

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 126
(A-22)

Introduced by: Idaho

Subject: Providing Recommended Vaccines Under Medicare Parts B And C

Referred to: Reference Committee A

1 Whereas, Many vaccines are recommended for routine use by the Advisory Committee for
2 Immunization Practices (ACIP) for Medicare-eligible beneficiaries; and
3

4 Whereas, Medicare patients usually have the opportunity to obtain recommended routine
5 vaccines at their usual source of care in the outpatient medical home; and
6

7 Whereas, The AMA believes that all public and private insurers should include immunizations
8 recommended by ACIP as a covered benefit and that patients should receive all immunizations
9 recommended by ACIP; and
10

11 Whereas, Under Section 2713 of the Patient Protection and Affordable Care Act, all private
12 health plans are required to cover, without cost sharing, ACIP recommended routine
13 immunizations; and
14

15 Whereas, Medicare currently does not cover some ACIP recommended routine vaccines under
16 parts B and C which results in the outpatient medical home being excluded from providing
17 recommended routine vaccines to Medicare beneficiaries; therefore be it
18

19 RESOLVED, That our American Medical Association support the expansion of coverage of all
20 Advisory Committee for Immunization Practices (ACIP) recommended immunizations for routine
21 use as a covered benefit by all public and private health plans (New HOD Policy); and be it
22 further
23

24 RESOLVED, That our AMA advocate to the Centers for Medicare and Medicaid Services
25 (CMS), and Congress if necessary, for expanded coverage of all ACIP recommended
26 immunizations for routine use to be a covered benefit without patient cost under Medicare parts
27 B and C for Medicare beneficiaries. (Directive to Take Action)

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

Received: 05/11/22

RELEVANT AMA POLICY**Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875**

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11; BOT action in response to referred for decision Res. 422, A-11; Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-22)

Introduced by: Michigan

Subject: Continuity of Care Upon Release from Correctional Systems

Referred to: Reference Committee A

1 Whereas, The rate of recidivism, or the re-entry of formerly incarcerated people, is 70 percent in
2 the United States of America, and more than 50 percent of those incarcerated have been
3 incarcerated more than once; and
4

5 Whereas, Roughly 20-25 percent of those incarcerated have a severe mental illness with up to
6 90 percent reporting consistently poor mental health; and
7

8 Whereas, Mental health problems are by far the most significant cause of morbidity and the vast
9 majority of mental health conditions are not detected upon release; and
10

11 Whereas, The general American population has a substance use rate of approximately seven
12 percent, people who are incarcerated have a substance use rate of approximately 38 percent
13 and are found to relapse approximately 50 percent of the time post-release; and
14

15 Whereas, Incarcerated people with major psychiatric disorders are at an increased risk of
16 multiple incarcerations, and risk factors such as certain psychiatric disorders, substance use,
17 and lack of treatment adherence are risk factors for recidivism within the correctional system;
18 and
19

20 Whereas, For formerly incarcerated people, the mental and substance use services they receive
21 post-release are critical but inconsistent or inadequate; and
22

23 Whereas, Assertive and continuous post-release social work, consisting of frequent mental
24 health check-ins and referrals to addiction support groups significantly showed more post-
25 release connections to mental health services as well as a significant reduction in recidivism;
26 and
27

28 Whereas, Only 28 percent of county jails screen inmates for Medicaid eligibility after release,
29 and in the U.S., 16 states have no formal procedure to enroll people in Medicaid post-release,
30 which serves as a barrier to crucial health care services; and
31

32 Whereas, These barriers not only lead to worsened and more costly health outcomes, but it also
33 increases the rates of recidivism; and
34

35 Whereas, Recidivism rates have been shown to fall when newly released incarcerated people
36 have assistance in accessing medications, their medical records, and primary and specialty
37 care; and

1 Whereas, In a national study of 1,434 ex-prisoners, 31.7 percent had three or more emergency
2 department (ED) visits compared with only 6.5 percent of adults in the general population
3 having two or more ED visits; and
4

5 Whereas, Individuals with recent criminal justice involvement represent only 4.2 percent of the
6 population, but they make up 8.5 percent of all ED expenditures, which translates to an
7 additional \$5.2 billion in annual spending across the health care sector; and
8

9 Whereas, When inmates in Rhode Island received medications for opioid use disorder while
10 incarcerated, post-release emergency department visits were decreased, and similarly when
11 inmates leaving prisons in California received transitional care (including medication refills and
12 expedited primary care appointments), they had half as many annual emergency department
13 visits; and
14

15 Whereas, In Ohio the Medicaid Pre-Enrollment Reentry program resulted in 30 percent of newly
16 enrolled individuals participating in substance use treatment and 38 percent of individuals
17 reporting the cost relief by Medicaid reduced their odds of recidivism; and
18

19 Whereas, In 2020, Maryland's Returning Citizens HealthLink Program worked with 3,453
20 inmates and determined that 86.8 percent qualified for Medicaid; of those that qualified, 89
21 percent were enrolled prior to release; therefore be it
22

23 RESOLVED, That our AMA amend policy AMA policy H-430.986, "Health Care While
24 Incarcerated," by addition and deletion to read as follows:
25

- 26 1. Our AMA advocates for adequate payment to health care providers, including
27 primary care and mental health, and addiction treatment professionals, to encourage
28 improved access to comprehensive physical and behavioral health care services to
29 juveniles and adults throughout the incarceration process from intake to re-entry into
30 the community.
- 31 2. Our AMA advocates and requires a smooth transition including partnerships and
32 information sharing between correctional systems, community health systems and
33 state insurance programs to provide access to a continuum of health care services for
34 juveniles and adults in the correctional system.
- 35 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid
36 applications from juveniles and adults who are incarcerated.
- 37 4. Our AMA encourages state Medicaid agencies to work with their local departments
38 of corrections, prisons, and jails to assist incarcerated juveniles and adults who may
39 not have been enrolled in Medicaid at the time of their incarceration to apply and
40 receive an eligibility determination for Medicaid.
- 41 5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility
42 of juveniles and adults upon intake into the criminal legal system and throughout the
43 incarceration process, and to reinstate coverage when the individual transitions back
44 into the community.
- 45 6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965
46 Social Security Act that bars the use of federal Medicaid matching funds from covering
47 healthcare services in jails and prisons.
- 48 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services
49 (CMS) to revise the Medicare statute and rescind related regulations that prevent
50 payment for medical care furnished to a Medicare beneficiary who is incarcerated or in
51 custody at the time the services are delivered.

- 1 8. Our AMA advocates for necessary programs and staff training to address the
2 distinctive health care needs of women and adolescent females who are incarcerated,
3 including gynecological care and obstetrics care for individuals who are pregnant or
4 postpartum.
- 5 9. Our AMA will collaborate with state medical societies, relevant medical specialty
6 societies, and federal regulators to emphasize the importance of hygiene and health
7 literacy information sessions, as well as information sessions on the science of
8 addiction, evidence-based addiction treatment including medications, and related
9 stigma reduction, for both individuals who are incarcerated and staff in correctional
10 facilities.
- 11 10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon
12 release in order to accelerate access to comprehensive health care, including mental
13 health and substance use disorder services, and improve health outcomes among this
14 vulnerable patient population, as well as adequate funding; ~~and~~ (b) the collaboration of
15 correctional health workers and community health care providers for those
16 transitioning from a correctional institution to the community; and (c) the provision of
17 longitudinal care from state supported social workers to perform foundational check-ins
18 that not only assess mental health but also develop lifestyle plans with newly released
19 people to support their employment, education, housing, healthcare, and safety.
- 20 11. Our AMA advocates for the continuation of federal funding for health insurance
21 benefits, including Medicaid, Medicare, and the Children's Health Insurance Program,
22 for otherwise eligible individuals in pre-trial detention.
- 23 12. Our AMA advocates for the prohibition of the use of co-payments to access
24 healthcare services in correctional facilities. (Modify Current HOD Policy)

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

Received: 05/11/22

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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 advocates and requires a smooth transition including 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. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. 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 use 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.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-22)

Introduced by: Women Physicians Section

Subject: Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level

Referred to: Reference Committee B

1 Whereas, The United States has the highest maternal and infant mortality rates among
2 comparable developed countries, specifically in survival rates of African American mothers and
3 their infants, ^{1,2}and the rates for maternal mortality and severe maternal morbidity are about
4 three times higher for women who received C-sections versus vaginal deliveries,³ and academic
5 consensus recommend an urgency in implementation and tracking of remedial actions;^{1,2} and
6

7 Whereas, In the United States, Black women are more likely to receive C-sections when
8 compared to other women of color groups and white women, when adjusted for variables, even
9 among low-risk cohorts; ^{3,4,5} and
10

11 Whereas, Mothers who were Medicaid recipients and received prenatal education and childbirth
12 support from trained doulas had lower odds of Cesarean sections and preterm births compared
13 to mothers who did not receive doula services;⁶ and
14

15 Whereas, Improving access to care, inclusivity of people of color, health prevention, affordable
16 healthcare and insurance coverage, tracking of quality outcome measures linked to provider
17 incentives are methods suited for eliminating racial disparities;^{5,6,7,8,9} and
18

19 Whereas, Eliminating barriers to training and licensure of a workforce pipeline inclusive of
20 doulas, midwives,^{6,10} and family physicians^{11,12,13} who provide maternity services made available
21 in rural and urban areas to supplement support to women can potentially reduce C-section rates
22 that put women and infants at risk;^{10,11,12,13} therefore, be it
23

24 RESOLVED, That our American Medical Association advocate for institutional and departmental
25 policies that promote awareness and transparency in defining the criteria for identifying and
26 mitigating gaps in health equity in Maternal Fetal outcome measures affecting racial and
27 minority U.S. population (Directive to Take Action); and be it further
28

29 RESOLVED, That our AMA engage with relevant stakeholders to initiate a similar awareness
30 campaign for public health education and health prevention at the grassroots level in the
31 communities, and advocate Medicaid and affordable insurance coverage for ancillary support
32 services. (Directive to Take Action)

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

Received: 05/04/22

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RELEVANT AMA POLICY**Disparities in Maternal Mortality D-420.993**

Our AMA: (1) will ask the Commission to End Health Care **Disparities** to evaluate the issue of health **disparities in maternal mortality** and offer recommendations to address existing **disparities in the rates of maternal mortality in the United States**; (2) will work with the CDC, HHS, state and county health departments to decrease **maternal mortality rates in the US**; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a **maternal mortality** surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, **maternal morbidity and maternal mortality in racial and ethnic minorities**.

CSAPH Rep. 3, A-09 Appended: Res. 403, A-11 Appended: Res. 417, A-18 Reaffirmed: Res. 229, A-21 Modified: Joint CMS/CSAPH Rep. 1, I-21

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress

or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.

5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

Citation: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-22)

Introduced by: Mississippi, Florida, Arizona, Texas, New Jersey, California

Subject: To Study the Economic Impact of Mid-Level Provider Employment in the United States of America

Referred to: Reference Committee B

Whereas, 24 out of 50 states have granted full practice rights for registered nurse practitioners (<https://www.aanp.org/advocacy/state/state-practice-environment>); and

Whereas, In a CDC funded study performed in 2016, it was discovered that patients were more frequently prescribed antibiotics if evaluated and treated by a NP or PA vs a physician only. The frequency of antibiotic prescriptions was 17% to 12% for overall visits and 61% to 54% for acute respiratory infection visits, respectively (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047413/>); and

Whereas, A study published in 2013 determined that the quality of referrals to an academic medical center was higher for physicians than that of NPs and PAs regarding the clarity of the referral question, understanding of pathophysiology, and adequate pre-referral evaluation and documentation ([https://www.mayoclinicproceedings.org/article/S0025-6196\(13\)00732-5/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/fulltext)); and

Whereas, A study published in *JAMA* in 2015 concluded that mid-level providers ordered more imaging studies during clinic visits (<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374>); and

Whereas, A study published in *JAMA Dermatology* in 2015 determined that the number needed to biopsy (NNB) for NP's/PA's was significantly higher compared to physicians. 2.9 v 5.9 respectively (<https://jamanetwork.com/journals/jamadermatology/fullarticle/2203840>); and

Whereas, A recent study published in the *Journal of the Mississippi State Medical Association* found that the care for over 33,000 Medicare patients provided by nonphysician providers was \$43 higher per patient per month than the care provided by physicians. This difference was estimated to add \$10.3 million annually to the cost of providing care to these patients if all of the care was provided by nonphysician providers. When adjusted for risk due to patient complexity, the cost increased to \$119 per patient per month or \$28.5 million annually (<https://www.ama-assn.org/print/pdf/node/82301>); therefore be it

RESOLVED, That our American Medical Association encourage and support studies sponsored by relevant state and federal agencies to determine the economic impact of mid-level unsupervised practice on American consumers (Directive to Take Action); and further be it

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action)

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

Received: 05/06/22

RELEVANT AMA POLICY

Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-22)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology, American College of Mohs Surgery, Society for Investigative Dermatology, American Society of Ophthalmic Plastic and Reconstructive Surgery, Louisiana, South Carolina, Missouri, Arizona, International Society of Hair Restoration Surgery, Iowa, Texas, Florida, Mississippi, Kansas, American Academy of Otolaryngology- Head and Neck Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Rheumatology

Subject: National Drug Shortages of Lidocaine and Saline Preparations

Referred to: Reference Committee B

Whereas, Despite repeated legislative attempts to alleviate national drug shortages, critical drug shortages for many medications, including lidocaine, lidocaine with epinephrine, and saline preparations remain; and

Whereas, There is need for greater transparency regarding what actions the Food and Drug Administration (FDA) has taken or plans to take to help alleviate current drug shortages; and

Whereas, Small and independent physician practices have minimal if any bargaining power with drug distributors and wholesalers, and thus are often disproportionately affected by drug shortages. Additionally, products in short supply are frequently allocated based on previous order history, which unfairly discriminates against new or growing medical practices; and

Whereas, National drug shortages negatively impact patients with the potential for delays in care and patient harm; therefore be it

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to draft a letter to the FDA calling for direct and prompt actions to alleviate current national shortages of lidocaine and normal saline preparations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages by addition and deletion to read as follows:

“8. Our AMA supports the view that wholesalers should routinely institute a transparent allocation-based system for distribution of drugs in short supply that does not discriminate against small, independent or new medical practices or those with less purchasing power ~~that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.~~” (Modify Current HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000
Received: 05/11/22

Reference:

US FDA: Current and Resolved Drug Shortages and Discontinuations Reported to the FDA,

<https://www.accessdata.fda.gov/scripts/drugshortages/>

Institute for Safe Medication Practices: Management of Drug Shortages with 0.9% Sodium Chloride, Sterile Water for Injection, and EPINEPHrine, [https://www.ismp.org/resources/management-drug-shortages-09-sodium-chloride-sterile-water-injection-and-](https://www.ismp.org/resources/management-drug-shortages-09-sodium-chloride-sterile-water-injection-and-epinephrine)

[epinephrine](https://www.ismp.org/resources/management-drug-shortages-09-sodium-chloride-sterile-water-injection-and-epinephrine)

RELEVANT AMA POLICY**National Drug Shortages H-100.956**

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of

global reporting requirements for indicators of drug shortages.

14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

Citation: CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: Res. 105, A-19; Modified: CSAPH Rep. 1, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: HPSA and MUA Designation for SNFs

Referred to: Reference Committee B

1 Whereas, Health professional shortage areas (HPSAs) and medically underserved areas
2 (MUAs) are areas, population groups, and facilities designated by the United States
3 Department of Health and Human Services as having met criteria indicating a significant
4 need for additional primary health care resources, such that limited resources can be
5 prioritized and directed to those areas to assist in addressing that need; and
6

7 Whereas, An area, population group, or facility designated as a HPSA or MUA has specific
8 programs made available to it targeted at enhancing primary care infrastructure through
9 recruitment and retention of health care providers and support for primary health care
10 facilities. Federal and State programs utilizing shortage designations as criteria for eligibility
11 include: National Health Service Corps, State Loan Repayment Program, NURSE Corps,
12 Federally Qualified Health Center and Health Center Look-Alike Certification, Medicare
13 Incentive Payment Program, CMS Rural Health Clinics Program, J-1 Visa Waiver and the
14 National Interest Waiver Programs, as well as scoring preferences for various Title VII and
15 VIII grants; and
16

17 Whereas, Due to a rapidly aging population, lack of commensurate increase in medical
18 school and residency positions, early retirement of healthcare professionals from burnout
19 and effects of the pandemic, and a lack of direct incentives to practice in senior living
20 communities, there is an acute shortage of healthcare professionals including Physicians,
21 nurses, and clinical practitioners in skilled nursing facilities. [https://www.aamc.org/news-](https://www.aamc.org/news-insights/us-physician-shortage-growing)
22 [insights/us-physician-shortage-growing](https://www.aamc.org/news-insights/us-physician-shortage-growing); therefore be it
23

24 RESOLVED, That our American Medical Association advocate for legislative action directing the
25 United States Department of Health and Human Services to designate all skilled nursing
26 facilities, irrespective of their geographic location, as health professional shortage areas and/or
27 medically underserved areas to facilitate recruitment and retention of health professionals using
28 the usual and customary support made available for such designations. (Directive to Take
29 Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Public Listing of Medical Directors for Nursing Facilities

Referred to: Reference Committee B

1 Whereas, In the early 1990s, the Centers for Medicare & Medicaid Services (CMS)
2 developed regulations and interpretive guidelines for the nursing facility (NF) medical
3 director's role: "to ensure that the facility provides appropriate care as required; monitors
4 and implements resident care policies; provides oversight and supervision of physician
5 services and the medical care of residents; plays a significant role in overseeing the overall
6 clinical care of residents to ensure to the extent possible that care is adequate; evaluates
7 situations as they arise and takes appropriate steps to try to correct the root cause, if
8 possible; consults with the resident and his or her physician concerning care and treatment,
9 if necessary; and ensures the support of essential medical consultants as needed;" and
10

11 Whereas, There is minimal public awareness of these guidelines, nor is there a public
12 listing of NF medical directors. Therefore, when there are deficiencies in clinical care of NF
13 residents or NFs' failure to implement resident care policies, the NF residents and their
14 families do not have ready access to NF medical director to request remediation of such
15 deficiencies by overseeing and coordinating clinical care of affected residents; and
16

17 Whereas, When such deficiencies in the clinical care of NF residents occur resulting in
18 adverse clinical outcomes, the residents and their families are forced to seek remediation
19 by complaining to their state public health departments bypassing the NF medical director,
20 thereby eliminating an opportunity for early interventions to 'correct the root cause' and to
21 improve quality of care for all NF residents; and
22

23 Whereas, Some NFs may elect to engage medical directors for the sole purpose of
24 referring admissions to their facilities, or medical directors without adequate training or
25 knowledge of geriatric medical principles, bioethics, and the complex regulatory framework
26 in which skilled nursing facilities operate, potentially resulting in bad outcomes and a lack of
27 quality control in these NFs; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for the Centers for Medicare &
30 Medicaid Services to promote health care transparency and consumer access to quality
31 health care by hosting a public listing of medical directors of all nursing facilities (NFs) in the
32 country. (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-22)

Introduced by: Association for Clinical Oncology

Subject: Coverage for Clinical Trial Ancillary Costs

Referred to: Reference Committee B

1 Whereas, Clinical trials are key to advancing new standards of care that can improve survival
2 and quality of life for people with cancer and other conditions; and
3

4 Whereas, Many patient populations continue to be underrepresented in trials, especially certain
5 racial and ethnic groups, older adults, rural residents, and those with limited incomes; and
6

7 Whereas, Private payers, Medicare, and Medicaid are responsible for covering routine care
8 costs associated with clinical trials, but patients are often left responsible for ancillary costs,
9 such as transportation to a trial site, lodging, meals, and additional childcare; and
10

11 Whereas, Ancillary costs can lead to lower rates of participation for lower-income patients as
12 well as rural patients who might not have trial sites nearby¹; and
13

14 Whereas, Some trial sponsors provide financial support for ancillary costs but others cite
15 concerns about running afoul of federal research participant protections that could subject them
16 to civil monetary penalties; and
17

18 Whereas, Pilot financial assistance programs that provide compensation for ancillary costs have
19 demonstrated promise in improving clinical trial accrual and clinical outcomes²; therefore be it
20

21 RESOLVED, That our American Medical Association amend Policy H-460.965, Viability of
22 Clinical Research Coverages and Reimbursement, as follows “...(11) legislation and regulatory
23 reform should be supported that establish program integrity/fraud and abuse safe harbors that
24 permit sponsors to cover co-pays/coinsurance/ deductibles, and otherwise not covered clinical
25 care, and non-clinical ancillary costs in the context of nationally approved clinical trials (Modify
26 Current HOD Policy); and be it further
27

28 RESOLVED, That our AMA actively advocate for federal and state legislation that would allow
29 coverage of non-clinical ancillary costs by sponsors of clinical trials. (Directive to Take Action)

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

Received: 05/11/22

¹ Journal of Clinical Oncology. Addressing Financial Barriers to Patient Participation in Clinical Trials: ASCO Policy Statement. Journal of Clinical Oncology website. <https://ascopubs.org/doi/pdf/10.1200/JCO.18.01132>. Published September 13, 2018. Accessed April 28, 2022.

² Nipp RD, Powell E, Finkelstein D, et al: 2014. Alleviating financial burden for cancer patients in clinical trials. J Clin Oncol 32, 2014 (suppl; abstr 10).

RELEVANT AMA POLICY

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.

Citation: 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-22)

Introduced by: Louisiana

Subject: Supporting Improvements to Patient Data Privacy

Referred to: Reference Committee B

1 Whereas, Patients are increasingly using smartphones, connected consumer devices, and
2 cloud-based applications to monitor vital signs, fitness metrics, and biological cycles, as well
3 as to store and maintain medical information as a personal health record; and
4

5 Whereas, Data collected through these tools and stored in personal digital applications is not
6 currently protected under HIPAA because software and technology companies and vendors
7 are not classified as covered entities; and
8

9 Whereas, It has been documented that certain health care providers have allowed Google, –
10 which owns large fitness tracker company Fitbit – access to sensitive medical records,
11 including visit location and time data, as part of a corporate partnership, without patient
12 permission or physician notification; and
13

14 Whereas, Sen. Bill Cassidy of Louisiana introduced the Stop Marketing and Revealing the
15 Wearables and Trackers Consumer Health Data Act (“Smartwatch Data Act”) – new federal
16 legislation to expand health data protections to include these types of device-collected
17 information; therefore be it
18

19 RESOLVED, That our American Medical Association support legislation to strengthen patient
20 data privacy protections by making health information collected or stored on smartphones and
21 similar consumer devices subject to the same privacy protections as standard medical records.
22 (New HOD Policy)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-22)

Introduced by: Michigan

Subject: Expanded Child Tax Credit

Referred to: Reference Committee B

1 Whereas, Poverty rates for individuals under the age of 18 increased from 14.4 percent in 2019
2 to 16.1 percent in 2020; and
3

4 Whereas, Children across most other racial categories are more likely to experience poverty
5 than their white counterparts and they are disproportionately represented among children in
6 poverty; and
7

8 Whereas, Child poverty negatively impacts children's physical, mental, and emotional health
9 and development, and this effect continues into adulthood; and
10

11 Whereas, The American Heart Association notes mounting evidence that mitigation of child
12 poverty improves cardiovascular outcomes in adulthood and recommends tax credits as one
13 means of mitigation; and
14

15 Whereas, The existing child tax credit legislation detailed in the American Recovery and
16 Reinvestment Plan of 2009 excludes roughly half of Latino and Black children because their
17 parents earn too little income to receive full benefit of that policy; and
18

19 Whereas, The expanded child tax credit included in the American Rescue Plan Act of 2021
20 dramatically and quickly reduced child poverty rates in the United States, including significant
21 reductions in poverty rates for Black and Latino children; and
22

23 Whereas, 91 percent of families with low incomes utilized funds provided through the expanded
24 child tax credit for necessities, including food, clothing, shelter, utilities, or education; and
25

26 Whereas, The expanded child tax credit included in the American Rescue Plan Act of 2021
27 ended in December 2021; and
28

29 Whereas, Seven states to date have successfully implemented a child tax credit to supplement
30 and strengthen that offered by federal legislation; therefore be it
31

32 RESOLVED, That our American Medical Association actively support the American Families
33 Plan of 2021 and/or similar policies that aim to institute a permanent, expanded child tax credit
34 at the federal level. (Directive to Take Action)

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

Received: 05/11/22

Sources:

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2. American Community Survey 2020. US Census Bureau. <https://www.census.gov/programs-surveys/acs/>. Published December 15, 2021
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9. Marr C, Cox K, Hingtgen S, Windham K, Sherman K. House covid relief bill includes critical expansions of Child Tax Credit and EITC. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/federal-tax/house-covid-relief-bill-includes-critical-expansions-of-child-tax-credit-and>. Published March 2, 2021
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11. Fox L. The Supplemental Poverty Measure: 2019. US Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-272.pdf>. Published September 2020
12. Zippel C. 9 in 10 families with low incomes are using child tax credits to pay for necessities, education. Center on Budget and Policy Priorities. <https://www.cbpp.org/blog/9-in-10-families-with-low-incomes-are-using-child-tax-credits-to-pay-for-necessities-education>. Published October 21, 2021
13. American Rescue Plan Act of 2021. 9 U.S.C. 9611-9612 (2021). <https://www.congress.gov/bill/117th-congress/house-bill/1319>
14. Child tax credit overview. National Conference of State Legislatures. <https://www.ncsl.org/research/human-services/child-tax-credit-overview.aspx>. Published February 1, 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-22)

Introduced by: Michigan

Subject: Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas

Referred to: Reference Committee B

1 Whereas, International medical graduates (IMG) resident physicians with J-1 visas can waive
2 the mandatory return to their native country as required per J-1 regulation and become eligible
3 to stay in the United States as a permanent resident by serving in underserved areas for three
4 years; and

5
6 Whereas, Their service is extremely helpful in improving the health of U.S. citizens, especially
7 low income and rural communities; and

8
9 Whereas, Substantial care to COVID-19 patients was provided by these J-1 visa waiver
10 physicians and they saved lives; and

11
12 Whereas, The waiting period for getting the green card visa for physicians of certain countries is
13 longer than 10 years at present due to the seven percent per country cap of visa conversions to
14 green cards, and the J-1 visa waiver physicians have to join the end of the very long queue of
15 1.2 million applicants for certain countries, and meanwhile their children are becoming status
16 less at age 18; and

17
18 Whereas, These J-1 visa waiver physicians provided great national service to US citizens, and
19 deserve priority in visa allotment; therefore be it

20
21 RESOLVED, That our American Medical Association lobby U.S. Congress and the U.S.
22 Administration that the J-1 visa waiver physicians serving in underserved areas be given highest
23 priority in visa conversion to green cards upon completion of their service commitment
24 obligation and be exempted from the per country limitation of H-1B to green card visa
25 conversion. (Directive to Take Action)

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

Received: 05/11/22

Sources:

1. <https://www.cato.org/publications/immigration-research-policy-brief/backlog-skilled-immigrants-tops-1-million-over#employment-based-green-card-backlog>
2. [1.4 Million Skilled Immigrants in Employment-Based Green Card Backlogs in 2021 | Cato at Liberty Blog](#)
3. [Letter to USCIS on Impact of Green Card Backlog on IMGs](#)
4. [Backlog for Skilled Immigrants Tops 1 Million: Over 200,000 Indians Could Die of Old Age While Awaiting Green Cards | Cato Institute](#)

RELEVANT AMA POLICY

J-1 Visas and Waivers D-255.993

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.
3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.
4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Citation: (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)

Conrad 30 - J-1 Visa Waivers D-255.985

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.

Citation: (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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-22)

Introduced by: Medical Student Section

Subject: Advancing the Role of Outdoor Recreation in Public Health

Referred to: Reference Committee B

1 Whereas, Mental illness and chronic diseases are extremely prevalent in the United States with
2 suicide, heart disease, and diabetes among the leading causes of death¹⁻³; and
3

4 Whereas, Outdoor recreation, defined as outdoor leisure time that occurs in urban, human-
5 made, and/or natural environments involving elements of nature such as terrain, plants, wildlife,
6 and water bodies, has been shown to positively impact physical, mental, and social health⁴⁻¹⁷;
7 and
8

9 Whereas, Outdoor recreation is associated with decreased risk of cardiovascular mortality and
10 myopia^{7,8}; and
11

12 Whereas, Compared to recreation in a non-natural environment, recreation in a natural outdoor
13 environment resulted in a 13.4-15.8% decrease in salivary cortisol levels and a 1.7-1.9%
14 reduction in systolic blood pressure⁹; and
15

16 Whereas, A 2018 Oregon study estimated that participation in outdoor recreation produces
17 between \$735 million and \$1.4 billion in savings per year related to chronic disease¹⁰; and
18

19 Whereas, Outdoor recreation can enhance well-being, happiness, and quality of life and
20 improve symptoms related to depression, stress, and post-traumatic stress disorder (PTSD),
21 particularly amongst veterans¹¹⁻¹⁷; and
22

23 Whereas, The National Recreation and Park Association and the CDC recognize the
24 importance of outdoor recreation to public health and support improving access to recreation
25 opportunities and continuing research efforts^{18,19}; and
26

27 Whereas, Public spaces available for outdoor recreation are increasingly threatened by
28 decreased public availability due to oil and gas leases and the impacts of climate change²⁰⁻²²;
29 and
30

31 Whereas, National Park visits increased 16% between 2013 and 2018 and continue to rise,
32 while discretionary and maintenance appropriations have remained stagnant, with nearly \$12
33 billion of deferred maintenance accumulated, a trend consistent across public recreation
34 agencies^{23,24}; and
35

36 Whereas, State parks are also affected by decreased spending with parks across Alabama,
37 Montana, Connecticut, Massachusetts, Wyoming, Minnesota, Texas, Utah and other states
38 facing threats of closure and maintenance backlogs²⁴⁻²⁹; and

1 Whereas, Decreased appropriations for recreation spaces may uniquely impact low-
2 socioeconomic and minority communities that already have lower quality public spaces for
3 recreation, decreased accessibility, and increased rates of space loss, despite these groups
4 disproportionately benefiting from outdoor recreation²⁹⁻³⁵; and
5

6 Whereas, With proven health benefits, outdoor recreation is now being considered as a
7 potential clinical tool via park prescriptions and outdoor organization referrals³⁶; and
8

9 Whereas, Outdoor recreation as therapy has had limited development in clinical application due
10 to insufficient program reach and resources, lack of available recreation spaces, and limited
11 research on the underlying mechanisms, and effective dose and duration^{12,37}; and
12

13 Whereas, Current AMA policies, including H-470.997 and H-135.973, encourage physical
14 activity and environmental stewardship but do not specifically address outdoor recreation, nor
15 do they include the unique exercise independent benefits and activities attributed to outdoor
16 recreation; and
17

18 Whereas, While AMA policy D-470.993 encourages creation of a set type of exercise venues at
19 the local level, this policy does not include many forms of outdoor recreation spaces and
20 activities, nor does it consider federal and state management of outdoor recreation spaces; and
21

22 Whereas, Our AMA would benefit from clear guidance on how to act on legislation related to
23 outdoor recreation such as H.R. 2435 and S.500/H.R. 1225 which were introduced in the 2019
24 cycle to expand opportunities for treatment and healing of military veterans through outdoor
25 recreation on public lands and to alleviate the maintenance backlog in National Parks and
26 Public Lands, respectively³⁸⁻⁴⁰; therefore be it
27

28 RESOLVED, That our American Medical Association encourage federal, state and local
29 governments to create new and maintain existing public lands and outdoor spaces for the
30 purposes of outdoor recreation; (Directive to Take Action) and be it further
31

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

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

Received: 05/11/22

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RELEVANT AMA POLICY

Government to Support Community Exercise Venues D-470.993

Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12

Exercise and Physical Fitness H-470.997

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

BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14

American's Health H-440.859

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

Res. 201, A-09; Reaffirmation, A-12

Physical Activity Guidelines H-60.979

Our AMA supports the continued expert review and development of national guidelines regarding physical activity for all ages and the dissemination of such guidelines to physicians. Res. 186, I-90; Reaffirmed: Sunset Report, I-00; Modified: BOT Rep. 10, A-14

Promotion of Exercise Within Medicine and Society H-470.990

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program.

Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation: I-98; Reaffirmation: A-07; Reaffirmed: BOT Rep. 21, A-12

Promotion of Exercise H-470.991

1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.

2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

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; Reaffirmed: CSAPH Rep. 1, A-21

Increasing Outdoor Activity to Prevent Myopia Onset and Progression in School Children H-60.913

Our AMA supports efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children.

Res. 405, A-17

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.

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

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.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

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.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of Res. 505, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-22)

Introduced by: Medical Student Section

Subject: Amending Policy H-155.955: Increasing Accessibility to Incontinence Products to include Diaper Tax Exemption

Referred to: Reference Committee B

1 Whereas, Diapers are used by different population groups, including but not limited to young
2 children and those with a variety of medical conditions¹; and
3

4 Whereas, The populations that utilize diapers often overlap with vulnerable patient groups, such
5 as infants/toddlers, the elderly, adults with physical disabilities, and adults with intellectual
6 disabilities, who are unable to independently perform activities of daily living including toilet
7 use¹; and
8

9 Whereas, Diapers that are not changed in a timely manner increase the risk of urinary tract
10 infections and diaper dermatitis, especially for extended hours spent in a diaper overnight; this
11 also creates an environment for the formation of pressure ulcers²⁻³; and
12

13 Whereas, Up to 36% of families struggle to afford child diapers, and diaper need (defined as the
14 lack of an adequate supply of clean diapers) can limit parents' ability to work, given that many
15 childcare centers require parents to supply diapers as a condition of enrollment³⁻⁶; and
16

17 Whereas, An American Academy of Pediatrics (AAP) study found that the average cost of
18 diapers is \$936 per year, per child, which is over 6% of a federal minimum wage salary of \$7.25
19 per hour^{3,7}; and
20

21 Whereas, An adult can expect to spend \$80-240 per month on diapers, depending on the
22 degree of incontinence and extent of need^{8,9}; and
23

24 Whereas, According to the National Diaper Bank Network, some families pay more in taxes for
25 diapers over a year than the cost of a one-month supply of diapers and, in 2014, the lowest
26 income quintile (with an average after-tax income of \$11,000) spent an estimated 14% of its
27 income on diapers^{10,11}; and
28

29 Whereas, Mothers reporting mental health needs were more likely to also report diaper need,
30 and in a population of low-income families in an urban setting, 30% of mothers who reported
31 diaper need were more likely to be Hispanic and older^{3,6}; and
32

33 Whereas, A study of the Vermont WIC (Women, Infants, and Children) Program, a low-income
34 based nutrition program, showed that 32.5% of families in the program reported diaper need¹²;
35 and
36

37 Whereas, Although the National Diaper Bank Network diaper distribution program assisted
38 280,000 children, it reached only 4% of the 7 million children living in families with incomes at or
39 below 200% of the federal poverty level¹³; and

Whereas, Medicaid coverage of child diapers deemed medically necessary for incontinence varies among states, with Utah, New Hampshire, and the District of Columbia having no age limit for beginning diaper coverage, while Maine, Kansas, and California begin coverage at 5 years¹⁴; and

Whereas, Thirty-six states charge sales tax on diapers; California, Connecticut, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont exempt diapers from taxation; and Maryland and North Dakota exempt adult incontinence products alone^{13,15}; and

Whereas, In a study of 50,000 households in low-income areas with a change in diaper tax status, implementation of sales tax exemptions for diapers was associated with a 5.4% increase in diaper spending and a 6.2% decrease in spending on children's pain medication, suggesting health benefits as a result of tax exemptions¹⁶; and

Whereas, As of 2021, thirteen states have adopted specific tax exemptions on menstrual products, illustrating the legislative and economic feasibility of exempting necessary hygiene products from taxable goods¹⁷; and

Whereas, Cost savings from the repeal of sales tax on menstrual products have been shown to directly benefit consumers, particularly those of lower-income backgrounds, by shifting the tax break mostly to consumers and away from manufacturers¹⁸; and

Whereas, Congress is currently considering multiple bills to both remove sales tax on diapers as well as make child diapers qualified medical expenses eligible for spending from pre-tax HSAs, HRAs, and FSAs¹⁹⁻²¹; and

Whereas, AMA Policy H-270.953 recognizes access to feminine hygiene products used for menstruation and other genital tract secretions as a public health issue and supports the removal of sales tax on all feminine hygiene products; and

Whereas, AMA Policy H-155.955 supports increased access to affordable incontinence products, but does not contain specific measures for implementation; therefore be it

RESOLVED, That our American Medical Association amend Policy H-155.955, "Increasing Accessibility to Incontinence Products," by addition and deletion as follows:

Increasing Accessibility to Incontinence Products H-155.955

Our AMA supports increased access to affordable incontinence products, the removal of sales tax on child and adult diapers, including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Res. 215, A-16

Infant Mortality in the United States H-245.986

It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special

health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.

BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Increasing Accessibility to Incontinence Products H-155.955

Our AMA supports increased access to affordable incontinence products.

Res. 908, I-18

Health Savings Accounts H-165.852

It is the policy of the AMA that: (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies; (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform; (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced; (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged; (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-22)

Introduced by: Medical Student Section

Subject: Expansion of Epinephrine Entity Stocking Legislation

Referred to: Reference Committee B

1 Whereas, Up to 5% of the US population has suffered anaphylaxis¹; and

2
3 Whereas, Common triggers of anaphylaxis are food, drugs, venom, and blood products²; and

4
5 Whereas, 5% to 8% of US children and 2% to 3% of US adults are at risk for anaphylaxis due to
6 food allergy¹; and

7
8 Whereas, Only 40.7% of children and 25% of adults with food allergies have an epinephrine
9 auto-injector prescription^{3,4}; and

10
11 Whereas, Low rates of epinephrine possession are particularly concerning given that nearly
12 40% of food-allergic adults reported at least one lifetime food allergy-related emergency
13 department visit, and more than half reported a history of one or more severe food-allergic
14 reactions⁴; and

15
16 Whereas, The prevalence of penicillin allergy in the US is 10%, with 6.8% suffering from
17 anaphylaxis⁵; and

18
19 Whereas, Most deaths from anaphylaxis have been associated with delayed administration of
20 epinephrine⁶; and

21
22 Whereas, A study showed that patients who received epinephrine earlier were less likely to be
23 hospitalized compared to those who received it later at the emergency room (17% vs 43%)⁷;
24 and

25
26 Whereas, Accidental injections can occur in a variety of circumstances, such as placing the
27 thumb on the tip of the epinephrine auto-injector during administration or children playing with
28 the devices⁸; and

29
30 Whereas, While recent data suggests that accidental epinephrine injections and lacerations are
31 a serious concern, these appear to be rare adverse events and usually require limited medical
32 intervention⁸; and

33
34 Whereas, To ensure proper treatment of anaphylaxis, epinephrine auto-injectors should always
35 be replaced before they expire⁸; and

36
37 Whereas, In situations concerning the safety and efficacy of expired epinephrine, overall, the
38 benefits of using epinephrine auto-injectors outweigh the potential risks⁸; and

Whereas, As of July 2019, 36 states have passed epinephrine entity stocking laws that allow authorized entities defined by each state to obtain and administer epinephrine auto-injectors to individuals undergoing an anaphylactic reaction⁹; and

Whereas, All authorized entities with possession of epinephrine auto-injectors are required to complete any certification and training requirements set forth by their state health department¹⁰; and

Whereas, Completion of certification requirements for epinephrine auto-injectors typically protects the entity, employees of the entity, and healthcare providers prescribing epinephrine from any subsequent liabilities¹⁰; and

Whereas, The passage of an epinephrine entity stocking law in Michigan was cited as a reason for the University of Michigan to have onsite auto-injectable epinephrine in their dining halls starting in fall 2019¹¹; and

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

Whereas, Individual states have defined authorized entities differently with many states employing broad definitions, such as the state of Florida that has defined one as “an entity or organization at which allergens capable of causing anaphylaxis may be present”^{10,12}; therefore be it

RESOLVED, That our American Medical Association support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Decreasing Epinephrine Auto-Injector Accidents and Misuse H-115.968

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

Res. 513, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Food Allergic Reactions in Schools and Airplanes H-440.884

Our AMA recommends that all:

- (1) schools provide increased student and teacher education on the danger of food allergies;
- (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and
- (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Preventing Allergic Reactions in Food Service Establishments D-440.932

Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

Res. 416, A-15

Over-the-Counter Inhalers in Asthma H-115.972

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

CSA Rep. 2, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 927, I-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-22)

Introduced by: Medical Student Section

Subject: Support for Warning Labels on Firearm Ammunition Packaging

Referred to: Reference Committee B

1 Whereas, Over 45,200 firearm-related deaths occurred in the United States in 2020, equating to
2 13.7 firearm-related deaths per 100,000 population and 124 deaths each day, making it the
3 worst year on record for firearm-related deaths¹; and
4

5 Whereas, Firearms are the second-leading cause of death of children in the U.S.²; and
6

7 Whereas, Over half of the firearm-related deaths in the U.S. are due to suicide and access to a
8 firearm increases suicide risk by seven times³; and
9

10 Whereas, Access to a firearm doubles the risk of death by homicide⁴; and
11

12 Whereas, Women in the U.S. are 25 times more likely to be killed with firearms than in other
13 high-income countries and in homes where domestic violence occurs, a firearm increases the
14 risk of women being killed by five times⁵; and
15

16 Whereas, Over 40% of Americans live in a household with at least one firearm, but fewer than
17 44% store their firearms unloaded and separate from the ammunition, which is recognized as a
18 best practice to reduce the risk of firearm-related suicide and injury⁶⁻¹⁰; and
19

20 Whereas, Relatively few federal or state regulations on ammunition exist, despite evidence that
21 reduced availability of ammunition has been associated with reduced firearm-related mortality<sup>7-
22 12</sup>; and
23

24 Whereas, Text-based warning labels have been shown to and may be effective in reducing
25 harmful health behaviors such as consumption of high-sugar or nutritionally poor foods,
26 consumption of alcohol, and misuse of medications¹³⁻²⁰; and
27

28 Whereas, A large body of evidence shows graphic warning labels on tobacco packaging
29 consistently reduce tobacco use, are more effective at changing behaviors and cognitive
30 patterns than text-only warnings, and are equally effective for many diverse population
31 subgroups^{14,21-34,37,38}; and
32

33 Whereas, Graphic pictorial warning labels have also been shown to have greater potential
34 benefits than text-based warnings in reducing alcohol use, sugary drink consumption, and
35 gambling^{14,21-34,37,38}; and
36

37 Whereas, In May 2019, the #DontLookAway campaign proposed requiring graphic warning
38 labels depicting potential harms on firearm ammunition packaging in the U.S. alongside public
39 health statistics concerning firearm-related harms^{39,40}; and

1 Whereas, No published studies currently exist concerning warning labels or graphic warning
2 labels on ammunition or firearms packaging; in the U.S., this may be attributable to restrictions
3 on firearms research while in other developed nations it is likely due to strong restrictions on
4 firearm ownership and purchasing, which results in markedly lower firearm ownership and
5 ammunition consumption⁴¹⁻⁴⁸; and
6

7 Whereas, In 2019, California began implementing Assembly Bill 1525, which requires warning
8 labels detailing firearm risks and firearm regulation laws be included on all packaging of firearms
9 and located on the premises of licensed firearms dealers, illustrating such requirements can be
10 enacted, though no research has yet been published on their effectiveness⁴⁹; and
11

12 Whereas, Our AMA supports warning labels on packaging of foods high in added sugars (D-
13 150.974), foods containing high fructose corn syrup (D-150.981), wire-bristle grill brushes (D-
14 10.991), detergents (D-60.967), waterbeds and beanbag furniture (H-245.985), indoor tanning
15 equipment (H-440.839), noise-producing toys (H-440.897), energy beverages (D-150.976),
16 latex-containing products (H-480.970), hand-held devices (H-15.952), and nicotine and tobacco
17 products (H-495.973), and our AMA supports graphic warning labels on tobacco packaging (H-
18 495.989); and
19

20 Whereas, Our AMA recognizes firearms as a public health problem (H-145.997) and gun
21 violence as a public health crisis (D-145.995); therefore be it
22

23 RESOLVED, That our American Medical Association support legislation requiring that
24 packaging for any firearm ammunition produced in, sold in, or exported from the United States
25 carry a legible, boxed warning that includes, at a minimum, (a) text-based statistics and/or
26 graphic picture-based warning labels related to the risks, harms, and mortality associated with
27 firearm ownership and use, and (b) explicit recommendations that ammunition be stored
28 securely and separately from firearms. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Tobacco Product Labeling H-495.989

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

CSA Rep. 3, A-04, Modified: Res. 402, A-13, Modified: Res. 925, I-16, Modified: Res. 428, A-19

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.

Res. 422, A-14, Appended: Res. 903, I-18

The Health Effects of High Fructose Syrup D-150.981

Our AMA:

(1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;

(2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and

(3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet.

CSAPH Rep. 3, A-08, Reaffirmation: A-13

Grill Brush Warning D-10.991

Our AMA will request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

Res. 423, A-18

Support for Detergent Poisoning and Child Safety Act D-60.967

1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.

2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method, so children know that the product is dangerous to ingest.

3. Our AMA encourages the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of "F3159-15 - Consumer Safety Specification for Liquid Laundry Packets" to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury.

Res. 430, A-16, Appended: Res. 413, A-17

Mandatory Labeling for Waterbeds and Beanbag Furniture H-245.985

The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag.

Res. 414, A-92, Reaffirmed: CSA Rep. 8, A-03, Modified: CSAPH Rep. 1, A-13

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839

1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

Tanning Parlors: Our AMA supports: (1) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (2) legislation to strengthen state laws to make the consumer as informed and safe as possible; (3) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (4) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (5) the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR ?1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (6) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (7) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (8) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (9) intensified efforts to enforce current regulations.

Sunscreens: Our AMA supports: (1) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sunshade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun. CCB/CLRPD Rep. 3, A-14, Appended: Res. 403, A-14, Appended: Res. 404, A-19, Appended: Res. 905, I-19

Noise Induced Hearing Loss In Children And Adolescents H-440.897

1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents.
 2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour.
 3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL.
 4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.
 Res. 407, I-00, Reaffirmed: CSAPH Rep. 6, A-08, Appended: Res. 411, A-16

Hazards of Energy Beverages - Their Abuse and Regulation D-150.976

1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).
 2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.
 3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.
 Res. 909, I-11, Appended: Res. 409, A-13

Latex Allergy Warning H-480.970

The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care.
 Sub. Res. 503, A-96, Appended: Res. 504, I-97, Reaffirmed: CSAPH Rep. 3, A-07, Reaffirmed: CSAPH Rep. 1, A-17

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our AMA encourages physicians to educate their patients regarding the public health risks of distracted driving, which includes the risks of visual distraction – taking one's eyes off the road, manual distraction – taking one's hands off the wheel, and cognitive distraction – taking one's mind off what they are doing.
 2. Our AMA will: (a) support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.
 3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
 4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
 5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
 6. Our AMA will make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with interested stakeholders.
 Res. 217, I-08, Appended: Res. 905, I-09, Appended: BOT Rep. 10, A-13, Appended: Res. 416, A-13, Modified in lieu of Res. 414, A-15, Appended: Res. 425, A-19, Appended: BOT Rep. 12, I-19, Modified: BOT Rep. 17, I-21

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents,

and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Res. 206, I-13, Modified in lieu of: Res. 511, A-14, Modified in lieu of: Res. 518, A-14, Modified in lieu of: Res. 519, A-14, Modified: CSAPH Rep. 2, I-14, Reaffirmation, A-15, Reaffirmed in lieu of: Res. 412, A-15, Reaffirmed in lieu of Res. 419, A-15, Reaffirmed: Res. 421, A-15, Reaffirmation A-16, Appended: Res. 429, A-18, Modified: CSAPH Rep. 05, A-18, Reaffirmation: I-19

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

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. Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: 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.

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

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. Res. 425, I-98, Reaffirmed: Res. 409, A-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmation A-13

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

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.
 Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 402, A-18

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.
 Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.
 Res. 214, I-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
 Sub. Res. 31, I-81, Reaffirmed: CLRPD Rep. F, I-91, Amended: BOT Rep. 50, I-93, Reaffirmed: Res. 409, A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Modified: Res. 401, A-17, Reaffirmation: 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.
 Res. 171, A-89, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSAP Rep. 8, A-05, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation A-18

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.
 Sub. Res. 34, I-89, Reaffirmed: BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-18, Reaffirmation: I-18

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.

Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 433, A-18; Reaffirmation: A-18

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19

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. 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

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89, Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmation: A-13, Reaffirmed: CSAPH Rep. 04, A-18, Reaffirmation: I-18, Modified: 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.

Sub. Res. 221, A-13, Appended: Res. 416, A-14, Reaffirmed: Res. 426, A-16, Reaffirmed: BOT Rep. 28, A-18, Reaffirmation: A-18, Modified: CSAPH Rep. 04, A-18, Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. Res. 219, I-11, Reaffirmation: A-13, Modified: Res. 903, I-13, Appended: Res. 419, A-17, Reaffirmed: CSAPH Rep. 4, A-18; Reaffirmed: CSAPH Rep. 3, I-21

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Res. 216, A-15

Safety of Non-powder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of non-powder (gas-loaded/spring-loaded) guns.

Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Res. 811, I-94, Reaffirmed: CSA Rep. 6, A-04, Reaffirmation: A-13

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms. Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Res. 201, I-16

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Res. 410, A-93, Reaffirmed: CLRPD Rep. 5, A-03, Reaffirmation: A-13, Modified: CSAPH Rep. 1, A-13

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths. Res. 410, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-22)

Introduced by: Medical Student Section

Subject: Updating Policy on Immigration Laws, Rules, Legislation, and 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, Throughout the COVID-19 pandemic, there were at least 48 immigration policy
5 changes that not only affected international travel, student visas, immigration, and asylum
6 processes, but also caused significant confusion for immigration lawyers²⁻⁴; and
7

8 Whereas, The suspension of the United States Custom and Immigration Services (USCIS)
9 during the early stages of the COVID-19 pandemic led to a back-up in the processing of
10 necessary documentation, which left many unable to access certain benefits necessary for
11 work, receiving healthcare, and accessing public benefits⁵; and
12

13 Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-
14 detained individuals on March 18, 2020, which delayed the processing of asylum seekers
15 enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary
16 conditions that promotes the spread of the virus⁵; and
17

18 Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create
19 rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted entry
20 at the northern and southern borders and barred asylum seekers from entering the country due
21 to public health threats, despite evidence suggesting that such restrictions are ineffective and
22 may even divert resources from other interventions⁵; and
23

24 Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed
25 hearings for detained people, prolonging their stay in detention centers^{4,5}; and
26

27 Whereas, The relief packages that were provided by the government during the pandemic either
28 provided little or no coverage to immigrants and their families, leaving them with few options for
29 testing and treatment⁵⁻⁷; and
30

31 Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19
32 related services available under emergency Medicaid, which means that immigrants are unable
33 to access these services since they cannot apply for non-emergency Medicaid due to
34 immigration eligibility criteria^{1,5,8}; and
35

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

Whereas, Lapses in work authorization due to slowed processing times and suspension of required processing services may result in immigrants being unemployed or losing benefits offered by their employer; further, undocumented immigrants typically work low-earning jobs and are unable to receive unemployment insurance or government stimulus checks during national crises^{5,8,9}; and

Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI) programs, but due to lapses in work authorizations, many immigrants may either not qualify or lose access to this vital benefit¹; and

Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-rays, which together are compared to growth charts to determine the age of an individual¹⁰; and

Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs, and dental x-rays may not correlate with the true chronological age of an individual due to population and geography-specific factors, including nutritional intake, environmental exposure, and genetics to such an extent that the Centers for Disease Control (CDC) recommends against using hand-wrist radiographs to determine the age of refugees¹⁰⁻¹⁴; and

Whereas, International records highlight the wide variety in growth charts used in different countries, in part due to different genetics, nutrition, medical conditions, and environmental exposures¹⁵⁻¹⁷; and

Whereas, The Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS) can request new skeletal and dental x-ray imaging to establish the age of an individual crossing the border, though the DHS handbook states that medical images may be used only when no other means of verifying chronological age (records from birth, baptism, school, healthcare, statements by the person in question or family members) exist¹⁸⁻²⁰; and

Whereas, According to Food and Drug Administration recommendations, performing x-rays on children comes with greater risk of radiation-related illness and should only be used to answer a clinical question or to guide treatment¹⁹; and

Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for child age determination and has since decreased their use of age determination exams^{21,22}; and

Whereas, In 2018, ICE decreased its number of age determination exams to less than 50; meanwhile, HHS increased its utilization of the exams for those in the care of the Office of Refugee Resettlement (ORR) to almost 700, almost double the number granted to both agencies in each of the prior two years²²; and

Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are held in adult detention centers while waiting for their cases to be heard and therefore are not held in the least restrictive setting, in violation of the Flores settlement agreement^{23,24}; and

Whereas, Attorneys representing minors report that their clients' supporting documentation was not used and were instead placed in adult detention centers solely based on x-ray images for months until federal judges ruled that ICE and HHS could not classify their immigrant clients as adults based solely on imaging²⁵; and

1 Whereas, AMA policy recognizes unique health needs of immigrants and refugees (H-350.957)
2 and opposes rules deter immigrants from utilizing non-cash public benefits (D-440.927) but
3 does not address protections for immigrants during national crises; and
4

5 Whereas, AMA policy advocates that healthcare for minors in detention centers should be
6 directed solely towards bettering health (H-65.958) and that medical records should not be used
7 for immigration enforcement (H-315.966); therefore be it
8

9 RESOLVED, That our American Medical Association, in order to prioritize the unique health
10 needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a
11 pandemic:

12 (1) oppose the slowing or halting of the release of individuals and families that are currently part
13 of the immigration process;

14 (2) oppose continual detention when the health of these groups is at risk and supports releasing
15 immigrants on recognizance, community support, bonding, or a formal monitoring program
16 during national crises that impose a health risk;

17 (3) support the extension or reauthorization of visas that were valid prior to a national crisis if the
18 crisis causes the halting of immigration processing; and

19 (4) oppose utilizing public health concerns to deny or significantly hinder eligibility for asylum
20 status to immigrants, refugees, or migrant workers without a viable, medically sound alternative
21 solution; (New HOD Policy) and be it further
22

23 RESOLVED, That our AMA support discontinuation of the use of non-medically necessary
24 dental and bone forensics to assess an immigrant's age. (New HOD Policy)

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

Received: 05/11/22

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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; Reaffirmed: CME Rep. 4, A-21

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-22)

Introduced by: Ohio

Subject: Improving the Veterans Health Administration Referrals for Veterans for Care
outside the VA System

Referred to: Reference Committee B

1 Whereas, Scandal at the Department of Veterans Affairs regarding wait times and access to
2 referral for specialty care resulted in reforms permitting expedited referral of VA patients to
3 doctors outside the VA system if prompt care could not be provided within the system; and
4

5 Whereas, A whistleblower-prompted VA internal investigation confirmed that in 2017 alone, for
6 2,538 veterans, doctors outside the VA system were terminating services to the veterans and/or
7 referring them to collection agencies, and impacting their credit profiles, because the VA was
8 not providing the indicated pay for services provided; and
9

10 Whereas, Investigation also determined that the software system for managing travel
11 reimbursement for the veterans referred outside the VA for care is obsolete, resulting in
12 \$224 million in improper travel reimbursements in 2017 alone; and
13

14 Whereas, The House Committee on Veterans' Affairs plans a hearing this spring to address
15 these issues; therefore be it
16

17 RESOLVED, The our American Medical Association advocate for reform of the veterans' health
18 administration to provide timely and complete payment for veterans' care received outside the
19 VA system and accurate and efficient management of travel reimbursement for that care.
20 (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-22)

Introduced by: Ohio

Subject: Out-of-Network Care

Referred to: Reference Committee B

Whereas, Many patients receive care from physicians who are not in their insurance company's restrictive network for multiple reasons; and

Whereas, This leads to out-of-network bills that are unexpected both to patients and physicians, especially in Emergency situations; and

Whereas, There are multiple potential legislative solutions being considered both at the national and state levels to address this problem; and

Whereas, AMA Policy H-285.904 only addresses permitting mediation 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; therefore be it

RESOLVED, That our American Medical Association amend, by substitution, AMA Policy H-285.904, "Out-of-Network Care," item H, to read as follows:

~~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.~~

H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers. (Modify Current HOD Policy)

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

Received: 05/10/22

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

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.

Citation: 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; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-22)

Introduced by: Ohio

Subject: Prescription Drug Dispensing Policies

Referred to: Reference Committee B

1 Whereas, In some states a pharmacist may dispense a 90-day supply of medication, when a
2 30-day supply with 2 or more refills is ordered, without approval by the physician, unless the
3 prescription specifically states DAW; and
4

5 Whereas, Suicides may involve an overdose of certain prescription medications; and
6

7 Whereas, Physician may not be aware of a patients suicide potential; and
8

9 Whereas, There are major restrictions on the prescribing of opiates and other controlled
10 substances, other prescription medications may be used by patients to end their lives; and
11

12 Whereas, It may be unsafe to leave the decision of whether to dispense a 90-day supply of
13 medication, when a 30-day supply with 2 refills has been ordered by the prescriber, up to "the
14 Pharmacist's Professional discretion after consulting with the patient;" therefore be it
15

16 RESOLVED, That our American Medical Association work with pharmacy benefit managers to
17 eliminate financial incentives for patients to receive a supply of medication greater than
18 prescribed (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA create model state legislation that would restrict dispensing
21 medication quantities greater than prescribed (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA support any legislation that would remove financial barriers favoring
24 dispensing quantities of medication greater than prescribed. (New HOD Policy)

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

Received: 05/10/22

RELEVANT AMA POLICY

Adequate Prescription Medication Supply H-120.943

1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.

2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis.

Citation: Res. 510, A-07; Reaffirmed: CMS Rep. 04, A-16; Appended: Res. 918, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-22)

Introduced by: Texas

Subject: COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians

Referred to: Reference Committee B

1 Whereas, During the initial phases of the COVID-19 pandemic, many physician practices relied
2 on the Economic Injury Disaster Loan (EIDL) federal small business loan program; and
3

4 Whereas, EIDL supports recovery from the COVID-19 disaster's economic impacts by providing
5 accessible and borrower-friendly capital; and
6

7 Whereas, The EIDL has a loan term of 30 years at 3.75% fixed interest rate for for-profits and
8 2.75% fixed interest rate for nonprofits; and
9

10 Whereas, The Small Business Administration (SBA) is taking real estate as collateral for loans
11 more than \$500,000, and personal guarantee for loans more than \$200,000; and
12

13 Whereas, Two forms of EIDL loans, those fully forgiven and those with low interest rates, are
14 available; and
15

16 Whereas, More than half the money from the U.S Department of the Treasury's Coronavirus
17 Relief Fund for small businesses went to only 5% of recipients, according to data on more than
18 5 million loans issued via the Payroll Protection Program, and only 28% of the money was
19 distributed in amounts of less than \$150,000; and
20

21 Whereas, Payroll costs for health care employees have risen exponentially since the pandemic
22 began (and continue to rise); and
23

24 Whereas, No increase in Medicare, Medicaid, or commercial insurance fee schedules has
25 occurred despite this hardship; and
26

27 Whereas, Given this inequity of available government assistance, many small businesses either
28 failed, took out non-forgiven loans to remain open, increased their workload, or underwent other
29 hardships to stay in operation; and
30

31 Whereas, Small businesses that successfully maximized their productivity and intentionally
32 reduced operating costs (through actions that cannot be maintained long-term, such as
33 postponing staff training and delaying equipment upgrades) were unfairly penalized by
34 government assistance programs and denied the same level of relief afforded to large
35 businesses that did not reduce their expenditures and were therefore able to demonstrate
36 financial losses; therefore be it

- 1 RESOLVED, That our American Medical Association advocate for Economic Injury Disaster
- 2 Loan (EIDL) forgiveness for physician groups of five or fewer physicians for loans of less than
- 3 \$150,000 granted by the Small Business Administration by whatever mechanism is available,
- 4 with no stipulations based on productivity or profit/loss reports to receive this forgiveness.
- 5 (Directive to Take Action)

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

Received: 05/09/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-22)

Introduced by: Idaho

Subject: Virtual Services When Patients Are Away From Their Medical Home

Referred to: Reference Committee B

1 Whereas, Virtual telemedicine care is a tool that can increase access, lower cost, and improve
2 the quality of healthcare; and
3

4 Whereas, Due to rapid changes in virtual technology, and increasing patient mobility, the
5 practice of medicine may need to occur across state lines to facilitate continuity of care for Idaho
6 patients who are receiving care from an Idaho licensed physician; and
7

8 Whereas, Continuity of care is defined by the American Academy of Family Physicians as, “the
9 process by which the patient and his/her physician-led care team are cooperatively involved in
10 ongoing health care management toward the shared goal of high-quality, cost-effective medical
11 care;” and
12

13 Whereas, Two elements have been shown to predict the best healthcare outcomes - health
14 insurance coverage and a usual source of continuity of care; and
15

16 Whereas, Idaho law requires a physician to be licensed in Idaho and establish a physician-
17 patient relationship in accordance with Idaho law in order to treat patients located in Idaho using
18 telehealth technology; and
19

20 Whereas, The practitioner who the patient has an established relationship with at their medical
21 home is in the best position to provide continuity of care, particularly if enabling technology is
22 available; and
23

24 Whereas, Health insurance coverage, including Medicare Advantage part C, is often restricted
25 to networks defined by regional or state boundaries; therefore be it
26

27 RESOLVED, That our American Medical Association support Medicare coverage of virtual
28 continuity of care follow-up services for patients within the physician’s established medical home
29 when the patient has an established relationship with the provider and such care is not
30 prohibited by the state in which the patient is geographically situated at the time of service
31 (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA advocate with the Centers for Medicare and Medicaid Services
34 (CMS), and Congress if necessary, to cover virtual continuity follow-up care services provided
35 by a patient’s established medical home or usual source of care, as if they were in person, even
36 if the patient is temporarily located outside of the region or state of their medical home.
37 (Directive to Take Action)

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

Received: 05/11/22

RELEVANT AMA POLICY

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
- e) The delivery of telemedicine services must be consistent with state scope of practice laws.
- f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
- g) The standards and scope of telemedicine services should be consistent with related in-person services.
- h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
- i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
- j) The patient's medical history must be collected as part of the provision of any telemedicine service.
- k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
- l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

- m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
- Citation: 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; Reaffirmed: CMS Rep. 8, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-22)

Introduced by: Carl S. Wehri, MD, Delegate

Subject: Physician Payment Reform & Equity (PPR & E)

Referred to: Reference Committee B

1 Whereas, Physicians in independent practice are running small businesses and employ tens of
2 thousands of American workers; and
3

4 Whereas, According to the Medicare Economic Index, the cost of running a medical practice
5 increased 39 percent from 2001 to 2021; and
6

7 Whereas, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff
8 for a physician's office continues to increase with inflation; and
9

10 Whereas, According to data from the Medicare Trustees, Medicare physician pay has increased
11 just 11 percent over the last 20 years while Medicare hospital payments increased by 60% from
12 2001 to 2021; and
13

14 Whereas, Adjusted for inflation, Medicare physician pay *declined* 20 percent from 2001 to 2021,
15 while hospital payment far surpassed inflation in this period; and
16

17 Whereas, Cost/price pressures have reduced the number of independent practice physicians,
18 and have threatened the viability of independent medical practice; and
19

20 Whereas, The loss of the private practice of medicine will have a profound impact on the
21 availability of high-quality, cost-effective medical care for many patients across this nation; and
22

23 Whereas, Improved payments for physician work will aid all physicians, both independent and
24 employed, as increased payment for physician services will also improve the value of RVUs that
25 our employed physician colleagues depend on for their compensation; and
26

27 Whereas, Our AMA has long had policy on improving payments for physician work, but it has
28 little to show in terms of concrete actions and results to accomplish said policy; therefore be it
29

30 RESOLVED, That our American Medical Association define Physician Payment Reform and
31 Equity (PPR & E) as "improvement in physician payment by Medicare and other third-party
32 payers so that physician reimbursement covers current office practice expenses at rates that
33 are fair and equitable, and that said equity include annual updates in payment rates" (Directive
34 to Take Action); and be it further
35

36 RESOLVED, That our AMA place Physician Payment Reform and Equity as the single highest
37 advocacy priority of our organization (Directive to Take Action); and be it further

1 RESOLVED, That our AMA use every resource at its disposal (including but not limited to
2 elective, legislative, regulatory, and lobbying efforts) to advocate for an immediate increase in
3 Medicare physician payments to help cover the expense of office practice (Directive to Take
4 Action); and be it further

5
6 RESOLVED, That in addition to an immediate increase in Medicare physician payments, our
7 AMA advocate for a statutory annual update in such payments that would equal or exceed the
8 Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in
9 covering the continuously inflating costs of running an office practice (Directive to Take Action);
10 and be it further

11
12 RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to
13 outline a specific set of steps that are needed to accomplish the goals of Physician Payment
14 Reform and Equity and report back to the HOD at the 2022 Interim Meeting regarding that plan
15 (Directive to Take Action); and be it further

16
17 RESOLVED, That our report back to the HOD at each subsequent meeting regarding their
18 progress on meeting the goals of Physician Payment Reform and Equity, until Physician
19 Payment Reform and Equity is accomplished. (Directive to Take Action)

Fiscal Note: Estimated cost of \$320K to implement resolution.

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-22)

Introduced by: Missouri

Subject: Unmatched Graduate Physician Workforce

Referred to: Reference Committee B

1 Whereas, The United States is expected to have an alarming shortage of physicians in primary
2 and specialty care; and
3

4 Whereas, The number of practicing physicians is decreasing due to burnout, retirement, and
5 other causes; and
6

7 Whereas, The current number of medical students, residents, and fellows will not prevent such
8 a shortage; and
9

10 Whereas, Congress has repeatedly failed to provide funding to educate the necessary number
11 of physicians to provide needed care of our aging and expanding population; and
12

13 Whereas, Physician Assistants (PAs) and Nurse Practitioners (NPs) have increasingly replaced
14 licensed physicians in providing primary and some specialty care due to geographic and
15 economic shortage of physicians; and
16

17 Whereas, Many States have allowed non-physician extenders to practice medicine
18 independently rather than under the supervision of and/or in collaboration with licensed
19 physicians; and
20

21 Whereas, A large number of physicians graduate from medical schools, take and pass USMLE
22 part one and two, then apply for residency, but fail to get one of the limited number of post-
23 graduate training spots in the US; and
24

25 Whereas, These graduating physicians spend six to eight years in undergraduate and graduate
26 studies before graduating, and some of them serve a year of internship required to graduate.
27 They spend huge sums of money to complete their studies, sit for and pass the rigorous USMLE
28 tests, spend thousands of dollars on their applications for the matching programs and
29 interviews; and
30

31 Whereas, These unfortunate physicians face the very hard reality of a sudden irreversible
32 interruption of their careers, outstanding debts they cannot repay, and the grim fact that others
33 who are less qualified, less educated, and less financially burdened individuals such as PAs and
34 NPs can practice medicine with or without collaborating with a licensed physician; and
35

36 Whereas, Missouri passed a law several years ago allowing these unfortunate graduating
37 physicians to obtain a license called Assistant Physician (AP) which allow these physicians
38 without residency to work in underserved areas in primary care in collaboration with a licensed
39 Missouri physician; and

1 Whereas, Several other States passed similar laws, under different titles such as Graduate
2 Physician and Associate Physician; and
3

4 Whereas, These graduating physicians working in collaboration with licensed physicians face in
5 their daily collaborative practices the denial of reimbursement by Medicare while Medicaid and
6 private insurers recognize their billings; and
7

8 Whereas, The AMA House of Delegates opposed, several years ago, the creation of this class
9 of licensees mainly because its creation may weaken our case in Congress for increased
10 funding for GME; and
11

12 Whereas, The number of these unfortunate graduating physicians has grown by the thousands
13 each year, yet Congress did not provide the needed funding to create enough residency slots to
14 train these physicians, while more non-physicians providing medical care increased dramatically
15 and many of them are now allowed to practice independently; and
16

17 Whereas, Many of these graduating physicians, after practicing in collaboration with licensed
18 physicians and acquiring additional skills and experience, were able to match into a residency
19 program; therefore, be it
20

21 RESOLVED, That our American Medical Association work with state societies to support these
22 unmatched graduate physicians through their legislators and regulators to allow these
23 physicians to work in underserved areas, in primary care, only in collaboration with a licensed
24 physician (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA work with appropriate parties and the Centers for Medicare and
27 Medicaid Services to reimburse for services rendered by these graduating physicians working in
28 their collaborative practices as do private insurers and state Medicaid programs (Directive to
29 Take Action); and be it further
30

31 RESOLVED, That the AMA allow these graduating physicians, working in collaboration with a
32 licensed physician, to become members of an AMA subgroup (Directive to Take Action); and be
33 it further
34

35 RESOLVED, That our AMA oppose any effort by these graduating physicians working in
36 collaboration with licensed physicians, to become independent licensed physicians without
37 satisfactorily completing formal residency training. (Directive to Take Action)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-22)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American College of Surgeons, American Gastroenterological Association, American Orthopaedic Foot & Ankle Society, American Society for Dermatologic Surgery, American Society for Gastrointestinal Endoscopy; American Society for Surgery of the Hand, American Society of Cataract and Refractive Surgery, American Society of Echocardiography, American Society of Interventional Pain Physicians, International Society for the Advancement of Spine Surgery, North American Spine Society, California, Florida, Texas

Subject: Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System

Referred to: Reference Committee B

1 Whereas, Physicians have been enduring financial instability in the Medicare physician payment
2 system due to a confluence of fiscal uncertainties related to the COVID-19 pandemic, ongoing
3 payment cuts, a lack of inflationary updates and increased administrative barriers; and
4

5 Whereas, Because of this uncertainty and instability, less than one-half of physicians (and for
6 some specialties, the percentage is even higher) now work in private practice, and as private
7 equity, hospitals systems and others acquire physician practices, this consolidation will continue
8 to drive up health care costs; and
9

10 Whereas, According to data from the Medicare Trustees, physician payments have barely
11 changed for nearly two decades, increasing just 7 percent from 2001 to 2020; in comparison,
12 hospital and skilled nursing facility updates totaled approximately 60 percent during this same
13 time frame; and
14

15 Whereas, Based on the Medicare Economic Index, the cost of running a medical practice
16 increased 37 percent between 2001 and 2020, and economy-wide inflation, as measured by the
17 Consumer Price Index, increased 46 percent over this period; and
18

19 Whereas, Physicians are bracing for another round of steep Medicare Physician Fee Schedule
20 (PFS) payment cuts in 2023 due to the continuation of the 2% Medicare sequestration, 4% pay-
21 as-you-go cuts, elimination of the 3% payment adjustment and other PFS changes triggering
22 the budget-neutrality adjustment; and
23

24 Whereas, Medicare's efforts to move from fee-for-service to value-based care are stalled, due to
25 flaws in the Merit-based Incentive Payment System and a lack of Advanced-Alternative
26 Payment Models in which physicians of all specialties can participate; and

1 Whereas, Steep payment cuts could jeopardize patients' timely access to care, particularly if
2 physicians are forced to limit the number of Medicare patients they treat due to low
3 reimbursement rates; and
4

5 Whereas, Preventing Medicare physician payment cuts in 2023 and passing broader Medicare
6 payment reform legislation will require a comprehensive, well-funded, sustained public
7 education and advocacy campaign on behalf of all physicians; and
8

9 Whereas, According to the 2021 Annual Report, the AMA has \$1.2 billion in assets with \$887.6
10 million in reserves, of which \$386.5 million is available above the minimum reserve portfolio,
11 and these funds provide the AMA with the ability to fund major strategic spending initiatives that
12 are not within the AMA's operating budget; and
13

14 Whereas, A highly visible public awareness and advocacy campaign would demonstrate the
15 AMA's leadership on this issue, which would be well received by physicians and help drive
16 membership in the AMA; therefore be it
17

18 RESOLVED, That our American Medical Association immediately launch and sustain a well-
19 funded comprehensive public awareness and advocacy campaign, that includes paid
20 advertising, social and earned media, and patient and physician grassroots, to prevent/mitigate
21 future Medicare payment cuts and lay the groundwork to pass federal legislation that reforms
22 the current Medicare physician payment system by incorporating annual inflation updates,
23 eliminating/replacing or revising budget neutrality requirements, offering a variety of payment
24 models and incentives to promote value-based care and safeguarding access to high-quality
25 care by advancing health equity and reducing disparities. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is between \$1,010,000 to \$25,060,000.

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-22)

Introduced by: Ohio

Subject: Appropriate Physician Payment for Office-Based Services

Referred to: Reference Committee B

1 Whereas, Physicians in independent practice are running small businesses and employ tens of
2 thousands of American workers; and
3

4 Whereas, According to the Medicare Economic Index, the cost of running a medical practice
5 increased 39 percent from 2001 to 2021; and
6

7 Whereas, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff
8 for a physician's office continues to increase with inflation; and
9

10 Whereas, According to data from the Medicare Trustees, Medicare physician pay has increased
11 just 11 percent over the last 20 years while Medicare hospital payments increased by 60% from
12 2001 to 2021; and
13

14 Whereas, Adjusted for inflation, Medicare physician pay declined 20 percent from 2001 to 2021,
15 while hospital payment far surpassed inflation in this period; and
16

17 Whereas, Cost/price pressures have reduced the number of independent practice physicians,
18 and have threatened the viability of independent medical practice; and
19

20 Whereas, The loss of the private practice of medicine will have a profound impact on the
21 availability of high-quality, cost-effective medical care for many patients across this nation; and
22

23 Whereas, Improved payments for physician work will aid all physicians, both independent and
24 employed, as increased payment for physician services will also improve the value of RVUs that
25 our employed physician colleagues depend on for their compensation; and
26

27 Whereas, Our AMA has long had policy on improving payments for physician work, but it has
28 little to show in terms of concrete actions and results to accomplish said policy; therefore be it
29

30 RESOLVED, That our American Medical Association advocate for improvement in physician
31 payment by Medicare and other third-party payers so that physician reimbursement covers
32 current office practice expenses at rates that are fair and equitable, and that said equity include
33 annual updates in payment rates to account for increased costs of running a medical practice.
34 (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-22)

Introduced by: Ohio

Subject: Prohibit Reversal of Prior Authorization

Referred to: Reference Committee B

1 Whereas, The process of obtaining prior authorization requires several steps that take
2 significant physician and staff time; and
3

4 Whereas, After prior authorization is obtained, the insurance company sends a letter or other
5 communication stating that the test, procedure, or medication is approved; and
6

7 Whereas, After receiving such communication, the physician will proceed with ordering the
8 approved testing, scheduling the procedure, or giving the approved medication; and
9

10 Whereas, After the testing or procedure is scheduled or done or the medication is given,
11 physicians and patients have received a second communication from the insurance company
12 reversing the prior authorization and denying payment; and
13

14 Whereas, Many of the prior authorization letters have a statement such as: "This notification is
15 not an approval for claim payment. This is confirmation of referral/authorization only;" and
16

17 Whereas, This is unfair to the patient and physician who proceed in good faith to do the testing
18 or procedure or provide the medication; therefore be it
19

20 RESOLVED, That once the physician's office has received prior authorization for testing, a
21 procedure, or a medication, the insurance company should not be permitted to refuse payment
22 for that test or procedure or medication unless the patient is no longer insured by that company
23 at the time the test or procedure is done or the medication is given; and be it further
24

25 RESOLVED, That a health insuring corporation or utilization review organization that authorizes
26 a proposed admission, treatment, or health care service by a participating provider based upon
27 the complete and accurate submission of all necessary information relative to an eligible
28 enrollee should not retroactively deny this authorization if the provider renders the health care
29 service in good faith and pursuant to the authorization and all of the terms and conditions of the
30 provider's contract with the health insuring corporation, and be it further
31

32 RESOLVED, That our American Medical Association seek federal legislation/rules to prohibit
33 denial of payment by a Medicare Advantage plan for a previously prior approved medication,
34 procedure, or test unless the patient is no longer insured by that company at the time of service
35 (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA redistribute its model legislation on retrospective denial of payment
38 to all state societies, especially those who have not already passed such legislation. (Directive
39 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000
Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-22)

Introduced by: Oklahoma

Subject: CME for Preceptorship

Referred to: Reference Committee C

1 Whereas, Continuing Medical Education (CME) credits are vital to all physicians; and

2
3 Whereas, Being a “preceptor” for medical students, residents, fellows, and other allied health
4 professional students requires countless hours of preparation; and

5
6 Whereas, The American Osteopathic Association (AOA) offers category 1B credit to its
7 members for participation in the AOA Didactic and Preceptor Program; and

8
9 Whereas, 60 AOA category 1B credits may be applied to the required 120 hours of CME for
10 AOA physicians; and

11
12 Whereas, The American Academy of Family Physicians offers CME credits to its members for
13 teaching of medical students, residents, and other allied health professional students; and

14
15 Whereas, The AMA does not recognize the AOA credits awarded for teaching and being a
16 preceptor; and

17
18 Whereas, Recognizing such efforts would encourage more physicians to be involved in
19 preceptor programs, which in turn would expose more students to the world of private practice
20 and the practice of medicine in more rural and underserved areas; therefore be it

21
22 RESOLVED, That our American Medical Association study formulating a plan, in collaboration
23 with other interested bodies, to award AMA Category 1 credits to physicians who serve as
24 preceptors and teach medical students, residents, fellows, and other allied health professional
25 students training in Liaison Committee on Medical Education/Accreditation Council for Graduate
26 Medical Education accredited institutions (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA devise a method of converting those credits awarded by other
29 organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action)

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

Received: 05/04/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Senior Living Community Training for Medical Students And Residents

Referred to: Reference Committee C

1 Whereas, Skilled nursing facilities (SNFs) and nursing facilities (NFs), assisted living
2 facilities (ALFs), and continuing care retirement communities (CCRCs) that incorporate a
3 combination of NFs, SNFs and ALFs with independent living communities (ILFs), are the
4 senior living communities (SLCs) where our nation's most vulnerable older and disabled
5 people reside; and
6

7 Whereas, Residents of SLCs are frail and functionally impaired, and often find it difficult to
8 access clinical care at traditional venues such as outpatient clinics and ambulatory centers,
9 and this lack of access to care results in unnecessary utilization of urgent care, emergency
10 departments and hospitals, where older persons are prone to developing adverse
11 outcomes; and
12

13 Whereas, SLCs, especially NFs, SNFs and ALFs are highly regulated by federal and state
14 governments, and the average primary care physician (PCP) does not venture to practice in
15 these care settings in part due to lack of familiarity with such regulations and difficulty in
16 complying with them; and
17

18 Whereas, Primary care training for medical students and residents requires exposure to
19 various care settings, including outpatient clinics, emergency rooms and hospitals,
20 exposure to SLCs has not been required by the Accreditation Council for Graduate Medical
21 Education (ACGME), thereby deepening the disconnect between PCPs and our vulnerable
22 elderly patients; and
23

24 Whereas, Specialty training in geriatric medicine is a part of medical school and primary
25 care residency programs, clinical care of our most vulnerable and frail patients in the SLC
26 setting is not required by ACGME during such training; and
27

28 Whereas, The COVID-19 pandemic and other healthcare crises and natural disasters have
29 proven it valuable for all clinicians to be familiar with all common healthcare settings, and
30 especially PALTC due to the unique nature of the care setting and our frail older and
31 disabled residents; therefore be it
32

33 RESOLVED, That our American Medical Association advocate to require training of medical
34 students and residents in senior living communities (to include nursing homes and assisted
35 living facilities) during their primary care rotations (internal medicine, family medicine and
36 geriatric medicine). (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-22)

Introduced by: Michigan

Subject: Tuition Cost Transparency

Referred to: Reference Committee C

1 Whereas, In 2018, the Association of American Medical Colleges (AAMC) reported that 76
2 percent of medical students graduated with a median loan debt of \$200,000. Compared to the
3 median medical student debt of \$50,000 in 1992, there is an approximate 220 percent increase
4 in medical school debt, even after accounting for the rate of inflation; and

5
6 Whereas, The capitalizing interest rates of Stafford Subsidized loans increased from 1.87
7 percent prior to 2006, to a current fixed rate of 6.87 percent, thereby exacerbating the rising
8 debt of medical students; and

9
10 Whereas, Higher levels of medical school debt are associated with worse academic outcomes
11 in undergraduate medical education, negative effects on mental well-being, and higher levels of
12 stress; and

13
14 Whereas, Higher medical school debt influences the way medical students approach major life
15 choices; students with higher aggregate amounts of debt were more likely to delay marriage or
16 having children and disagree that they would choose to become a physician again; and

17
18 Whereas, Medical students with higher debt compared to their peers were more likely to choose
19 a specialty with a higher annual income, were less likely to choose primary care, and less likely
20 to plan to practice in underserved locations; and

21
22 Whereas, The number of graduate medical students exceeds the number of available post
23 graduate year positions. The increasing number of students not matching, and the increase in
24 medical student debt can make medical school seem more of a financial risk; and

25
26 Whereas, The American Medical Association (AMA) supports continued assessment of the
27 value of graduate medical education (GME) and transparency of federal funding, which is
28 received by GME institutions; and

29
30 Whereas, Undergraduate medical students are not provided specific breakdowns of tuition costs
31 or reasons for tuition increases; and

32
33 Whereas, The AMA supports improving the systematic reporting of undergraduate medical
34 student expenditures to determine which items are included and the ranges of costs; therefore
35 be it

36
37 RESOLVED, That our American Medical Association collaborate with organizations such as the
38 Association of American Medical Colleges in creating transparency in tuition costs of
39 undergraduate medical education institutions (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA work with other national organizations to improve the affordability of
 2 medical education. (Directive to Take Action)

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

Received: 05/11/22

Sources:

1. AAMC. An Exploration of the Recent Decline in the Percentage of U.S. Medical School Graduates With Education Debt. https://www.aamc.org/download/296002/data/aibvol12_no2.pdf. Accessed January 13, 2020.
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4. Hill MR, Goicochea S, Merlo LJ. In their own words: stressors facing medical students in the millennial generation. *Med Educ Online*. 2018;23(1). doi:10.1080/10872981.2018.1530558
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RELEVANT AMA POLICY

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
 6. supports continued study of the relationship between medical student indebtedness and career choice;
 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
 9. encourages for-profit hospitals to participate in medical education and training;
 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
 12. will advocate that resident and fellow trainees should not be financially responsible for their training.
- Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will

increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

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

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

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

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

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

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

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

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are

utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-22)

Introduced by: Michigan

Subject: Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations

Referred to: Reference Committee C

1 Whereas, There are known complications of pregnancy, including but not limited to, carpal
2 tunnel syndrome, gestational diabetes, gastroesophageal reflux, morning sickness including
3 hyperemesis gravidarum, urinary tract or bladder infections, chronic migraines, and pelvic and
4 back pain, that can be disruptive to women's ability to complete workplace responsibilities; and
5

6 Whereas, Complications of pregnancy qualify as disabilities under the American Disability Act,
7 which requires employers to provide appropriate accommodations; and
8

9 Whereas, 53 percent of pregnant, working women felt the need to modify job requirements; and
10

11 Whereas, 70 percent of women report morning sickness in the first trimester; and
12

13 Whereas, In 2019, women accounted for 50.5% of all matriculating medical students; and
14

15 Whereas, Medical student parents face unique barriers to coordinating medical school
16 graduation requirements; and
17

18 Whereas, The majority of medical schools have scheduled licensing exam study periods and
19 deadlines by which students must complete testing with relative inflexibility in timing; and
20

21 Whereas, The Prometric testing sites for the USMLE exam provide minimal pregnancy
22 accommodations, limited to a trackball computer mouse, pillows for physical comfort, and
23 private testing rooms; and
24

25 Whereas, The Prometric testing sites for the USMLE exam provide minimal lactation
26 accommodations, limited to curtains or a pop-up tent for privacy during nursing or pumping; and
27

28 Whereas, The Personal Item Exceptions (PIEs) list of pre-approved items allowed within the
29 secure testing area provides limited pregnancy comfort aids, including glucose tablets, non-
30 electric heating pads, ice packs, pillow/lumbar support, and stools for limb elevation; and
31

32 Whereas, Neither the National Board of Medical Education (NBME) nor the contracted
33 Prometric Testing sites have a public, unified list of common pregnancy accommodations for the
34 USMLE exams, leaving candidates to find and cite multiple webpages to identify previously
35 approved accommodations for the USMLE; and
36

37 Whereas, The state of California provides graduate students in their public institutions the same
38 accommodations and support services to pregnant students and those recovering from
39 childbirth-related conditions as it would to other students with temporary medical conditions; and

Whereas, The American Board of Internal Medicine considers pregnancy and breastfeeding to be medical conditions worthy of accommodation for board exams and offers a core set of accommodations offered to all pregnant or nursing examinees, including extra break time and the opportunity to take the exam over two days; and

Whereas, Basic guidelines for lactation support at standardized testing centers have already been recognized by academic journals, including a private space for milk expression and storage of breastmilk ("lactation station") that is close to the testing site with furniture to support lactation including a chair to sit on while pumping, a power outlet, a sink for washing hands and/or cleaning pump parts, and a refrigerator and freezer to store expressed milk; therefore be it

RESOLVED, That our American Medical Association support and advocate for the implementation of 60 minutes of additional, scheduled break time for medical students and residents who have pregnancy complications and/or lactation needs for all NBME administered examinations, consistent with American Board of Internal Medicine accommodations (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for the addition of pregnancy comfort aids, including but not limited to, ginger teas, saltines, wastebaskets, and antiemetics, to the USMLE pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for pregnant individuals. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY**AMA Support for Breastfeeding H-245.982**

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Citation: CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 322
(A-22)

Introduced by: Michigan

Subject: Standards in Cultural Humility Training within Medical Education

Referred to: Reference Committee C

Whereas, Cultural humility within medicine is defined as “the lifelong commitment to self-evaluation and self-critique to redressing the power imbalances in patient-physician dynamic;” and

Whereas, Cultural humility is a skill that is beneficial for students and physicians to understand how their culture and identity influences patient encounters to become more culturally sensitive doctors, minimizing the risk of subconscious bias of personal beliefs onto a patient; and

Whereas, Cultural humility is distinct from cultural competence, as competency implies achievement of proficiency, while humility includes constant self-reflection and learning, focuses on the clinicians ability to connect on multiple levels to patients, and fosters cultural respect; and

Whereas, The Liaison Committee on Medical Education (LCME) introduced standards for cultural competency for all medical students upon graduation, yet medical schools are not explicitly required to have standards for cultural humility education within their curriculum; and

Whereas, There is existing literature outlining techniques to implement tools and coaching of cultural humility in the healthcare field, such as simulated teaching interventions, the 5R’s approach of developing humility (reflection, respect, regard, relevance, and resiliency), and self-reflective courses; and

Whereas, Several cultural minority groups experience barriers in receiving quality health care and have worse mortality and morbidity outcomes across various chronic diseases; and

Whereas, Training health care professionals in cultural humility is associated with higher scores on accountability, improved health care experiences, and increased empathy towards patients; therefore be it

RESOLVED, That our AMA amend policy H-295.897, “Enhancing the Cultural Competence of Physicians,” by addition to read as follows:

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.

3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

Citation: CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 323
(A-22)

Introduced by: Medical Student Section

Subject: Cultural Leave for American Indian Trainees

Referred to: Reference Committee C

1 Whereas, American Indian and Alaska Native students have disparately lower four-year medical
2 school graduation rates compared to their non-Hispanic white peers (71% vs. 87%)¹; and
3

4 Whereas, The Association of American Medical Colleges and Association of American Indian
5 Physicians recognize that perception of one's school/workplace environment influences medical
6 student retention and success and that a positive psychological climate can be fostered when
7 student programming and student affairs offices are responsive to American Indian and Alaska
8 Native culture and history¹; and
9

10 Whereas, A 2021 survey conducted by the Association of Native American Medical Students
11 found that 20% of respondents cited loss of culture and distance from family as significant
12 challenges to their progression in medical training;² and
13

14 Whereas, The American Indian Religious Freedom Act of 1978 requires protection and
15 preservation of American Indians' inherent right of freedom to believe, express, and exercise the
16 traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but
17 not limited to access to sites, use and possession of sacred objects, and the freedom to worship
18 through ceremonial and traditional rites³; and
19

20 Whereas, Despite this law, American Indian and Alaska Native K-12 students are more likely to
21 face disciplinary action in education systems, including suspension and expulsion, than their
22 peers due to a lack of cultural responsiveness⁴; and
23

24 Whereas, Cultural responsiveness enables individuals and organizations to respond respectfully
25 and effectively to people of all cultures, languages, classes, races, ethnic backgrounds,
26 disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that
27 recognizes, affirms, and values their worth⁵; and
28

29 Whereas, Culturally-responsive practices involve recognizing and incorporating the assets and
30 strengths all students bring into the classroom, and ensuring that learning experiences, from
31 curriculum through assessment, are relevant to all students, and are grounded in evidence-
32 based community practice⁶; and
33

34 Whereas, Existing AMA policy focused on equity, diversity and, inclusion (H-200.951, D-
35 200.985) is not specific to or inclusive of cultural leave practices; and
36

37 Whereas, American Indian and Alaska Native cultural responsiveness must be an ongoing and
38 deliberate effort, taking root across the school spectrum—curriculum, pedagogy, engagement
39 with students and their families, and overall policies and practices;⁷⁻⁸ and

Whereas, There is strong evidence that institutions must accommodate American Indian and Alaska Native cultural practices instead of relying on the student to navigate non-specific policies allowing for leave;⁹ therefore be it

RESOLVED, That our American Medical Association amend policy H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition and deletion to read as follows:

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923

Our AMA encourages residency programs, fellowship programs, and medical schools to:

(1) ~~make an effort to accommodate~~ Allow residents' trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other residents trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers. (Directive to Take Action)

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

Received: 05/11/22

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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.

CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

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.

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, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and 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; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented 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 goal; and (6) 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 marginalized patient populations.

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; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

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

CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14;

Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 324
(A-22)

Introduced by: Medical Student Section

Subject: Sexual Harassment Accreditation Standards for Medical Training Programs

Referred to: Reference Committee C

Whereas, Sexual harassment is defined as “sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (1) such conduct interferes with an individual’s work or academic performance or creates an intimidating, hostile, or offensive work or academic environment or (2) accepting or rejecting such conduct affects or may be perceived to affect employment decisions or academic evaluations concerning the individual” by the AMA Journal of Ethics and is “unethical...[and] raise[s] concerns because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees and may adversely affect patient care”¹; and

Whereas, According to the 2018 report from the National Academies of Sciences, Engineering, and Medicine, 49.6% of female students in medical school or in graduate school for a healthcare field have reported having experienced sexual harassment during their training²; and

Whereas, Female medical students are 220% more likely to experience unwanted crude behavior from faculty or staff compared to female students studying non-scientific fields²; and

Whereas, At one medical program, female medical students were more likely than their male colleagues to be physically sexually harassed and to be harassed by a person of higher professional status, resulting in 79% of female survivors and 45% of male survivors saying that the experience of sexual harassment created a “hostile environment” or interfered with work performance³; and

Whereas, Sexual harassment during training has been shown to have a significant impact on the specialty and residency program choices of female trainees⁴; and

Whereas, Female residents are more likely to experience sexual harassment during graduate medical education in fields such as surgery and emergency medicine compared to other specialties, with one study finding that 70.8% of female general surgery residents reported experiencing sexual harassment during training^{2,5}; and

Whereas, Female residents are more likely to experience sexual harassment in male-dominated workplaces, especially when leadership is male-dominated, and male physicians continue to be dramatically overrepresented in healthcare leadership positions, with 84% to 85% of department chair and medical dean appointments in 2013 to 2014, despite approximately equal female entrance into medicine^{2,6-9}; and

Whereas, Experiencing sexual harassment has been linked to poor job-related outcomes such as work withdrawal, a decrease in commitment to the organization, and reduction of job satisfaction, and sexual harassment has a stronger negative impact on a woman’s well-being

1 through psychological consequences such as anxiety and depression compared to general job
2 stressors such as workload and meeting deadlines^{2,10}; and

3
4 Whereas, Sexual harassment continues to be a problem in medicine despite federal protection
5 such as Title VII, Title IX, and the Clery Act, which intend to protect victims of sexual
6 harassment from gender discrimination and unwanted sexual attention¹¹⁻¹⁴; and

7
8 Whereas, Under Title IX, educational institutions are required to provide students and trainees
9 with resources for reporting sexual harassment, including information on their rights under Title
10 IX, how to contact the institution's Title IX coordinator, and how to file a complaint of sexual
11 harassment, and the institution must also have a policy how it will investigate and respond to
12 reported allegations of sexual harassment¹⁵; and

13
14 Whereas, Legal protections do not adequately protect trainees from covert retaliation, and fear
15 of retaliation accounts for 28% of the approximately 79% of cases of sexual harassment that go
16 unreported¹¹; and

17
18 Whereas, In the absence of an institutional culture that promotes sexual harassment training at
19 all levels and the importance of incident reporting as part of the solution to mitigate sexual
20 harassment, sexual harassment training and reporting methods are not effective at reducing
21 sexual harassment of medical trainees¹⁶⁻¹⁸; and

22
23 Whereas, A recent survey of pediatric, gastroenterology, and internal medicine residents
24 revealed that only 43% knew of institutional policies to support sexual harassment victims and a
25 2017 AAMC survey of medical students found that only 21% of students reported experiences
26 of sexual harassment, with 37% of those not reporting stating "I did not think anything would be
27 done about it" and 9% of those not reporting stating "I did not know what to do"^{11,19}; and

28
29 Whereas, The Liaison Committee on Medical Education (LCME) serves as the accrediting body
30 that holds all medical schools to 12 standards which ensure graduates have been adequately
31 trained to begin graduate medical education²⁰; and

32
33 Whereas, The LCME does not explicitly address sexual harassment in the written standards for
34 Anti-Discrimination and Student Mistreatment²¹; and

35
36 Whereas, LCME Standard 12 does explicitly address the need for medical schools to provide
37 "effective student services to all medical students to assist them in achieving the program's
38 goals for its students"²¹; and

39
40 Whereas, LCME Standard 12.3: Personal Counseling/Well-Being Programs states that, "A
41 medical school has in place an effective system of personal counseling for its medical students
42 that includes programs to promote their well-being and to facilitate their adjustment to the
43 physical and emotional demands of medical education," thereby establishing precedent for
44 specific standards on student well-being including for the concerns addressed herein²¹; and

45
46 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) serves as the
47 accrediting body that evaluates all residency and fellowship programs to ensure programs meet
48 the established quality standards for each specialty and subspecialty²²; and

49
50 Whereas, The ACGME requires residency and fellowship programs to maintain a professional
51 environment free from sexual harassment, but does not explicitly state how that standard is
52 evaluated^{23,24}; therefore be it

1 RESOLVED, That our American Medical Association encourage the LCME and ACGME to
 2 create a standard for accreditation that includes sexual harassment training, policies, and
 3 repercussions for sexual harassment in undergraduate and graduate medical programs;
 4 (Directive to Take Action) and be it further

5
 6 RESOLVED, That our AMA encourage the LCME and ACGME to assess: 1) medical trainees'
 7 perception of institutional culture regarding sexual harassment and preventative trainings and 2)
 8 sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource
 9 utilization in order to recommend best practices. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship. Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII

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

Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961

Principles for Advancing Gender Equity in Medicine:

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

BOT Rep. 27, A-19

Policy on Conduct at AMA Meetings and Events H-140.837

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held

in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees.

The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

BOT Rep. 23, A-17 Appended: BOT Rep. 20, A-18 Modified: BOT Rep. 10, A-19; Modified: CCB Rep. 2, I-20

CME Rep. 7, A-03 Modified and Appended: BOT Rep. 16, A-12

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; Reaffirmed: BOT Rep. 9, I-20

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

- (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
- (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
- (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
- (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
- (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
- (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
- (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
- (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
- (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
- (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
- (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals

and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

CME Rep. B, A-82 Amended: CLRPD Rep. A, I-92 Res. 331, I-95 Reaffirmed by Res. 322, A-97
 Reaffirmation I-03 Modified: CME Rep. 7, A-05 Modified: CME Rep. 2, I-05 Appended: CME Rep. 5, A-11
 Reaffirmed: CME Rep. 3, A-11 Modified: CME Rep. 01, I-17 Appended: Res. 961, I-18

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.
- CME Rep. 4, A-14 Appended: CME Rep. 10, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 325
(A-22)

Introduced by: Medical Student Section

Subject: Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

Referred to: Reference Committee C

1 Whereas, The Comprehensive Osteopathic Medical Licensing Examination (COMLEX) USA is a
2 licensing exam series that is currently required by the Commission on Osteopathic College
3 Accreditation (COCA) to be taken by all osteopathic medical students in order to graduate from
4 a COCA-accredited medical school¹; and

5
6 Whereas, The United States Medical Licensing Examination (USMLE) is a licensing exam
7 series that is currently taken by all allopathic medical students and some osteopathic medical
8 students²; and

9
10 Whereas, In 1997, 363 osteopathic medical student first-time test takers completed USMLE
11 Step 1 and Step 2 Clinical Knowledge (CK) and by 2020, that number had increased more than
12 23-fold, significantly outpacing the 3-fold growth in osteopathic medical school enrollment, so
13 that in 2020 70% of the first-time test-taking osteopathic students who took COMLEX Level 1
14 also took USMLE Step 1^{2,3,4}; and

15
16 Whereas, The growing trend of osteopathic students choosing to take the USMLE series in
17 addition to the COMLEX USA series further exacerbates the osteopathic medical student debt
18 burden, adding an approximate total of \$6,131,840 in additional examination fees for
19 osteopathic test takers during 2019-2020^{2,5}; and

20
21 Whereas, An increasing number of osteopathic medical schools have mandated students to
22 complete the USMLE and COMLEX USA series prior to graduation, despite evidence that a
23 minimal number of licensing examinations already significantly increase rates of stress, anxiety,
24 and depression amongst medical students⁶; and

25
26 Whereas, Two high-stakes licensing examinations establishing the same competency create
27 redundancy, as evident by strong correlation between USMLE Step 1 and Step 2 and respective
28 COMLEX Level 1 and 2 scores for residency applicants^{7,8,9}; and

29
30 Whereas, Although USMLE Step 1 and the COMLEX USA Level 1 will change to a pass/fail
31 scoring system by 2022, the USMLE Step 2 CK will remain a scored exam¹⁰; and

32
33 Whereas, In 2014, the American Osteopathic Association (AOA), American Association of
34 Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council of Graduate Medical
35 Education (ACGME) agreed to transition to a single accreditation system to increase
36 collaboration among the medical education community, reduce costs and increase efficiency,
37 and provide consistency¹¹; and

1 Whereas, The AOA has recognized the importance of modernizing board certification exams,
2 and are offering a new pathway of board certification that does not include and/or require
3 Osteopathic Manipulative Treatment (OMT), emphasizing the similarities between the allopathic
4 and osteopathic professions¹²; and
5

6 Whereas, Although the AMA has adopted policy H-295.876, *Equal Fees for Osteopathic and*
7 *Allopathic Medical Students*, which is currently being enacted by the AMA Council of Medical
8 Education, there is evidence that ACGME programs have and continue to discriminate against
9 osteopathic medical students who did not to take the USMLE series when selecting candidates
10 for away rotations and residencies^{13,14}; and
11

12 Whereas, Nearly 20% of ACGME program directors do not utilize the COMLEX USA series and
13 require the USMLE series as part of the residency selection process, putting osteopathic
14 medical students who elect not take USMLE series at a significant disadvantage^{11,13}; and
15

16 Whereas, Many ACGME program directors, and a majority of program directors in certain
17 specialties such as emergency medicine, consider it to be important for osteopathic students to
18 apply with USMLE series scores, and that in these specialties, osteopathic students who take
19 the USMLE series have a 20% better match rate^{13,15}; and
20

21 Whereas, Despite previously-enacted advocacy efforts regarding AMA resolution H-275.013,
22 *The Grading Policy for Medical Licensure Examination*, calling for equal recognition of the
23 COMLEX USA and USMLE series as licensing exams, recent data shows that 54% of VSAS
24 participating institutions require USMLE Step 1 scores for away rotations¹³; and
25

26 Whereas, The National Student Osteopathic Medical Association (SOMA) adopted resolution S-
27 20-30, *Single Licensing Exam*, encouraging the National Board of Osteopathic Medical
28 Examiners (NBOME), National Board of Medical Examiners (NBME), and Federation of State
29 Medical Boards (FSMB) to develop a single licensing examination series for all medical students
30 with an additional osteopathic specific subject test for osteopathic medical students^{16,17}; and
31

32 Whereas, Although the Coalition for Physician Accountability's Undergraduate Medical
33 Education-Graduate Medical Education Review Committee offered the solutions of standardized
34 score conversion between USMLE and the COMLEX-USA series, historically program directors
35 have required USMLE scores despite the long standing availability of COMLEX percentile
36 converters by the NBOME^{18,19}; and
37

38 Whereas, SOMA has advocated to the COCA to adjust their continuing accreditation standards
39 such that Element 6.12 no longer requires the COMLEX USA series to be passed prior to
40 graduation from an Osteopathic medical school, rather Osteopathic medical students must pass
41 a new single licensing exam developed by the NBOME, FSMB, and NBME²⁰; therefore be it,
42

43 RESOLVED, That our American Medical Association encourage the development of a single
44 licensing examination series for all medical students attending a medical school accredited by
45 the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic
46 College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for
47 osteopathic medical students. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY**Proposed Single Examination for Licensure H-275.962**

Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies.

CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.
 2. Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students.
 3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.
 4. Our AMA: (a) encourages the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students; and (b) encourages the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students.
- Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21

National Resident Matching Program Reform D-310.977

Our AMA:

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

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

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

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

CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21

Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950

Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialing bodies to encourage the elimination of these centralized, costly, and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.

Res. 306, I-20

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.

2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

5. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 326
(A-22)

Introduced by: Medical Student Section

Subject: Standardized Wellness Initiative Reporting

Referred to: Reference Committee C

1 Whereas, Existing studies of medical trainees have shown high rates of depression and anxiety,
2 both of which are known risk factors for suicide¹⁻⁴; and
3

4 Whereas, In one meta-analysis, the prevalence of depression or depressive symptoms among
5 medical students was 27%, with only 16% of those who screened positive seeking psychiatric
6 treatment; residents report depression at rates of 21-43%, with rates increasing over time^{3,5}; and
7

8 Whereas, Matriculating medical students have lower rates of depression and burnout compared
9 to the general population, a trend that quickly reverses when they begin medical school;
10 similarly, the first year of residency is associated with a 16% increase in depressive symptoms,
11 highlighting a need for additional support during that transition⁵⁻⁷; and
12

13 Whereas, Rates of burnout - a contributor to depression, relationship problems, and substance
14 use - are higher in all medical trainees compared to the general population^{8,9}; and
15

16 Whereas, Suicide rates in medical trainees are difficult to estimate due to lack of high-quality
17 data, particularly in the medical student population^{7,8,10}; and
18

19 Whereas, A study on causes of death in residents revealed suicide to be the second leading
20 cause (second only to cancer), and the leading cause of death for male residents¹¹; and
21

22 Whereas, There is limited data on depression, anxiety, and suicide in post-graduate physicians,
23 much of which comes from older data and small-scale studies, although a 2020 meta-analysis
24 subsequently found that suicide remains a leading cause of mortality for physicians when
25 compared to other causes (i.e., cardiovascular disease, cancer), despite a general decrease in
26 physician suicide rates since 1980; more recently, the Medscape Physician Burnout and Suicide
27 Report has become a powerful tool to track mental health trends anonymously within our
28 profession in real time¹²⁻¹⁵; and
29

30 Whereas, Overall, there are limited robust studies about medical student, resident, and
31 physician suicide, as noted in a 2015 *JAMA Psychiatry* viewpoint calling for a national response
32 regarding studies of depression and suicide in medical trainees¹⁶; and
33

34 Whereas, Increasing professional demands and worsening burnout related to the COVID-19
35 pandemic highlight the importance of collecting accurate, real-time data on our profession's
36 mental health to inform efforts on mitigating risks and preventing suicide¹⁷; and
37

38 Whereas, For allopathic medical school accreditation, the LCME requires that institutions
39 "include programs that promote student wellbeing;" for osteopathic medical school accreditation,
40 COCA requires that the institution "must develop and implement policies and procedures as well

as provide the human and physical resources required to support and promote health and wellness;" for residency, ACGME requires "Institution, must ensure healthy and safe learning and working environments that promote resident well-being"¹⁸⁻²⁰; and

Whereas, Wellness initiatives in medical schools and residency programs can vary widely in format—usually with preventative, reactive, and cultural programming, and rarely with structural programming—and effectiveness, and often face barriers such as insufficient financial or administrative support²¹⁻²³; and

Whereas, A public database of wellness initiatives of each medical school and residency would allow programs to display their own initiatives as well as gather ideas and contact information to more rapidly and effectively implement new ones; therefore be it

RESOLVED, That our American Medical Association amend D-345.983, "Study of Medical Student, Resident, and Physician Suicide," by addition to read as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students-; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness interventions in these populations. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.983

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

CME Rep. 06, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

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

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

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

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

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

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

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

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

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

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

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

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

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

CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

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.

AMA Principles of Medical Ethics: I,II,IV

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 327
(A-22)

Introduced by: New Jersey

Subject: Leadership Training Must Become an Integral Part of Medical Education

Referred to: Reference Committee C

1 *"No one other than physicians can do what physicians do. They have a unique skill set in*
2 *healing and "fixing" people. If doctors aren't willing to contribute their professional expertise in*
3 *these areas, they will essentially leave the health of their profession to those outside of the*
4 *profession" - General Mark Hertling*

5
6 Whereas, Physicians play a leading role in the healthcare team and are considered to be
7 ultimately responsible for the overall outcome of patient care (1); and

8
9 Whereas, Medical graduates are expected to "provide leadership skills that enhance team
10 functioning, the learning environment, and/or the healthcare delivery system" (1); and

11
12 Whereas, A physician's role as a leader of medicine is currently underestimated within the
13 current medical curriculum (6); and

14
15 Whereas, Medical students report that they do not feel that they have received an adequate
16 level of leadership training required to be an effective leader (5); and

17
18 Whereas, The number of medical programs implementing some form of leadership training into
19 their curriculum is growing, experiences are rare and inconsistent (6); and

20
21 Whereas, There is an essential need for a clearly developed and standardized form of training
22 that can be implemented throughout the graduate and postgraduate medical curriculum (4);
23 and

24
25 Whereas, Many schools lack formal leadership programs, which may reflect the time constraints
26 of existing curricula, limited resources, beliefs that leadership cannot be taught, lack of
27 consensus on leadership content, and other factors (2); and

28
29 Whereas, Students report a lack of support structure for practicing leadership skills, a lack of
30 opportunity to serve in a leadership position, and the number of time-related pressures present
31 for medical students during their training (4); and

32
33 Whereas, Addressing leadership training opportunities for physicians has been in the AMA
34 policy radar since at least 2018 per D-295.316, the urgency for implementation of concrete
35 steps cannot be overstated (9); therefore be it

36
37 RESOLVED, That our American Medical Association study the extent of the impact of AMA
38 Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum and
39 provide a report at the interim meeting (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate for the implementation of concrete steps to incorporate
- 2 leadership training as an integral part of the core curriculum of medical school education, post-
- 3 graduate training, and for practicing physicians.

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

Received: 05/10/22

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RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
 2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
 3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
- Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 328
(A-22)

Introduced by: Ohio

Subject: Increasing Transparency of the Resident Physician Application Process

Referred to: Reference Committee C

Whereas, The mean number of residency applications medical students send has increased dramatically the last two decades, in some specialties more than 100% ¹⁻³; and

Whereas, This trend of increased applications results in increased expense for medical students ^{4,5}; and

Whereas, This trend of increased applications also increases administrative burden for residency programs ^{1,6}; and

Whereas, Many residency programs use filters to pare down the number of residency applications they must consider ^{7,8}; and

Whereas, Many residency programs do not disclose the use of these filters to applicants, leading medical students to spend money on applications that will never be considered ⁷; and

Whereas, Increasing numbers of applications have made it difficult for residency directors to determine genuine interest from an applicant, leading to the proliferation of post-interview communication and third-party services as informal workarounds ^{9,10}; and

Whereas, Increasing transparency in residency applications has been proposed as a way to combat the increases in applications ¹¹⁻¹⁴; and

Whereas, Resolving uncertainty in the area of career development is recognized as one way of decreasing medical student and resident burnout ¹⁶; therefore be it

RESOLVED, That our American Medical Association, and interested stakeholders, study options for improving transparency in the resident application process. (Directive to Take Action)

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

Received: 05/10/22

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RELEVANT AMA POLICY

Policy Suggestions to Improve the National Resident Matching Program D-310.974

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) **work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.**

Citation: (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

National Resident Matching Program Reform D-310.977

Our AMA:

(1) will work with the National Resident Matching Program (NRMP) 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 (ACGME) 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 NRMP and 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;

(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; and

(18)

encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 329
(A-22)

Introduced by: Texas

Subject: Use of the Terms “Residency” and “Fellowship” by Health Professions
Outside of Medicine

Referred to: Reference Committee C

1 Whereas, The terms “residency” and “fellowship” have historical and valued meaning within
2 American medicine, dating back more than 100 years. In 1889 at Johns Hopkins Hospital,
3 William Osler, MD, established America's first formal residency program with interns and
4 residents residing in the hospital. Fellows stayed for additional years of training, and these roles
5 and references remain relevant; and

6
7 Whereas, Physicians pursuing specialty board certification are required to complete
8 standardized and accredited training referred to as residency, with the possibility for further sub-
9 specialized training referred to as fellowship; and

10
11 Whereas, Some postgraduate training programs for nonphysician clinicians, including
12 podiatrists, pharmacists, advanced practice registered nurses, and psychologists have started
13 using the same nomenclature, labeling their programs as residencies and fellowships; and

14
15 Whereas, The curricula for postgraduate medical training programs are well-defined and
16 standardized through a national accreditation process and informed by board-certification
17 requirements. The postgraduate training pathways for other health professionals do not require
18 the same rigor as medicine. They often are not standardized, and the content is vastly more
19 limited than medicine in depth, scope, and duration. The broad application of these terms to a
20 diversity of programs without the same complexity of training creates the potential for
21 misconceptions among the general public; and

22
23 Whereas, Using these terms to blur the lines between the training of physicians and other health
24 professions do not accurately reflect the distinctions between the training models and can
25 demean the definition of the field of medicine. These misconceptions also are used to support
26 scope-of-practice expansions in health professions outside medicine; and

27
28 Whereas, A survey of the public revealed confusion about which clinicians have medical
29 degrees or degrees of osteopathic medicine, and favored transparency of training; and

30
31 Whereas, The American Academy of Dermatology has stated that labeling nonphysician training
32 programs as residencies or fellowships is misleading and this terminology should apply only to
33 physician training programs; and

34
35 Whereas, In the patient care setting, the role of individual health care practitioners should be
36 clearly identified to patients and other health care practitioners. Name tags that identify
37 residents or fellows as physicians distinguishes them from other health care practitioners and
38 clarifies their role on the health care team; and

Whereas, The American Academy of Emergency Medicine has stated that training programs for physician assistants and advanced practice registered nurses should avoid use of the terms resident and fellow; and

Whereas, A national discussion by the American Medical Association is needed to prevent the continued distortion of these terms by nonphysician groups; therefore be it

RESOLVED, That our American Medical Association hold a national discussion about the historical value and current nature of the terms "residency" and "fellowship" to describe physician postgraduate training and address the ramifications of nonphysician clinician groups using similar nomenclature that can confuse the general public. (Directive to Take Action)

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

Received: 05/09/22

The topic of this resolution is currently under study by the Council on Medical Education.

References:

1. [A History of Medical Residency](#)
2. [Truth in Advertising survey results](#)
3. [AAEM and AAEM/RSA Position Statement on Emergency Medicine Training Programs for Non-Physician Practitioners](#)
4. [Position Statement on Dermatology Residency and Fellowship Training Nomenclature Exclusivity for U.S. Based Dermatology Residents and/or Fellows](#)

RELEVANT AMA POLICY

Non-Physician "Fellowship" Programs D-275.979

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.

Citation: (CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14)

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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-22)

Introduced by: California, American College of Physicians, Maine, Massachusetts, Oregon, Washington, Minnesota, American Medical Women's Association, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Declaring Climate Change a Public Health Crisis

Referred to: Reference Committee D

1 Whereas, Ahead of the November 2021 United Nations Climate Summit known as the
2 Conference of the Parties (COP26), over 200 international health journal editors made an
3 unprecedented joint statement that “the greatest threat to global public health is the continued
4 failure of world leaders to keep the global temperature rise below 1.5°C” to prevent catastrophic
5 and irreversible harms to public and global health¹; and
6

7 Whereas, The *Lancet* Countdown on Health and Climate Change has warned that the “rapidly
8 changing climate has dire implications for every aspect of human life, exposing vulnerable
9 populations to extremes of weather, altering patterns of infectious disease, and compromising
10 food security, safe drinking water, and clean air” earning it the title of the “greatest public health
11 challenge of the 21st century”²⁻⁴; and
12

13 Whereas, The U.S. health sector is responsible for an estimated 8.5% of national carbon
14 emissions— stemming directly from the operations of healthcare facilities (scope 1) and indirectly
15 from both purchased sources of energy, heating, and cooling (scope 2) and the supply chain of
16 healthcare services and goods (scope 3)⁵; and
17

18 Whereas, Our AMA is a member of the Steering Committee of the Action Collaborative on
19 Decarbonizing the Health Sector, which is part of the National Academy of Medicine Grand
20 Challenge on Climate Change, Human Health, & Equity; whose four strategic objectives are to:
21 (1) communicate the climate crisis as a public health and equity crisis, (2) develop a roadmap
22 for systems transformation, (3) catalyze the health sector to reduce its climate footprint and
23 ensure its resilience, and (4) accelerate research and innovation at the intersection of climate,
24 health and equity⁶; and
25

26 Whereas, In August 2021, the U.S. Department of Health & Human Services announced the
27 creation of the new Office of Climate Change and Health Equity (OCCHE), tasked with taking on
28 the health impacts of climate change and its effects such as extreme weather; and
29

30 Whereas, Our AMA does not currently have a strategic plan to respond to the climate health
31 crisis and most physician practices are not prepared to decarbonize our practices in alignment
32 with emerging national goals and regulations; and
33

34 Whereas, The longer-term health benefits of addressing climate change have been well
35 documented: preventing roughly 4.5 million deaths, 3.5 million hospitalizations and emergency
36 room visits and approximately 300 million lost workdays in the U.S. over the next 50 years, and
37 a rapid shift to a 2°C pathway could reduce the toll of air pollution, which leads to nearly
38 250,000 premature deaths per year in the US, by 40% in just a decade ^{7,8,9}; and

Whereas, The World Health Organization estimates that direct damage to health (not including costs of damage mediated by effects on agriculture, water, and sanitation) will reach \$2-4billion per year by 2030¹⁰; and

Whereas, Across all climate-related risks, children, older adults, low-income communities, outdoor workers, minoritized communities, and communities burdened by poor environmental quality are disproportionately affected¹¹⁻¹⁴; and

Whereas, '*Climate justice*' is a term used for framing global warming as an ethical and political issue, rather than one that is purely environmental or physical in nature by relating the effects of climate change to concepts of justice, particularly environmental justice and social justice and by examining issues such as equality, human rights; collective rights, and the historical responsibilities for climate change¹⁵; and

Whereas, To avoid the worst consequences of climate change by keeping global warming from pre-industrial levels to 1.5 degrees Celsius (2.7 degrees Fahrenheit), as outlined by the Intergovernmental Panel on Climate Change (IPCC) will require global greenhouse gas (GHG) emissions to have peaked by 2020 and net zero carbon emissions by 2050 at the latest, highlighting that we are in a "vanishing window of opportunity for meaningful action"^{16,17,18}; and

Whereas, Physicians are uniquely trusted messengers with a responsibility to advocate for science-based policies to safeguard health in the face of any public health crisis¹⁹; 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 actively coordinating strategic physician advocacy and 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* which commit our profession to "[earning] society's trust in the healing profession" by "[educating] the public and polity about present and future threats to the health of humanity" and "[advocating] for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" (*H-140.900*); therefore, be it

RESOLVED, That our American Medical Association declare climate change a public health crisis that threatens the health and well-being of all individuals (Directive to Take Action); and be it further

RESOLVED, That our AMA protect patients by advocating for policies that: (1) limit global warming to no more than 1.5 degrees Celsius, (2) reduce US greenhouse gas emissions, and (3) achieve a reduced-emissions economy (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. (Directive to Take Action)

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

Received: 05/06/22

The topic of this resolution is currently under study by the Council on Science and Public Health

References:

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6. National Academy of Medicine description of the Climate Collaborative: <https://nam.edu/wp-content/uploads/2021/09/Climate-Collaborative-one-pager-9.27.21.pdf>
7. Health and Economic Benefits of a 2°C Climate Policy <https://docs.house.gov/meetings/GO/GO00/20200805/110965/HHRG-116-GO00-WstateShindellD-20200805.pdf>
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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: 421
(A-22)

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
35

36 Whereas, Preliminary analyses have shown anal cancer screening to be cost effective for HIV-
37 positive individuals, MSM, and women with a history of cervical dysplasia with quality life
38 adjusted years (QALYs) increases of 4.4 years at a cost of \$34,763 per life year gained overall,
39 and particular cost effectiveness of annual anal pap testing for MSM at a cost of \$16,000 per
40 QALY saved⁸; therefore be it

- 1 RESOLVED, That our American Medical Association support advocacy efforts to implement
- 2 screening for anal cancer for high-risk populations (New HOD Policy); and be it further
- 3
- 4 RESOLVED, That our AMA support national medical specialty organizations and other
- 5 stakeholders in developing guidelines for interpretation, follow up, and management of anal
- 6 cancer screening results. (New HOD Policy)

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

Received: 05/06/22

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RELEVANT 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.

Citation: (Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Voting as a Social Determinant of Health

Referred to: Reference Committee D

1 Whereas, Social determinants of health are the non-medical unavoidable patient life conditions
2 that directly influence healthcare risks and account for 30%-55% of healthcare outcomes¹⁻³; and
3

4 Whereas, Citizens from historically excluded backgrounds are more affected by barriers to
5 voting than White citizens: in states that have strict voting ID laws, Latino turnout drops by 9.3%,
6 Black turnout by 8.6%, and Asian turnout by 12.5% after implementation of these laws
7 compared to previous voter turnout statistics⁴; and
8

9 Whereas, Experiencing barriers to participating in the electoral process is correlated with an
10 increased likelihood of being uninsured. In a national study on disparities in voter access, it was
11 demonstrated that an increase in barriers to voting access is associated with a 25% overall
12 greater probability of being uninsured⁵⁻⁹; and
13

14 Whereas, Individuals who experience voter suppression have disproportionately worse health
15 outcomes, and these disparities largely affect people of color. Given that Healthy People 2020
16 identified civic participation as a social determinant of health^{6,10-13}; and
17

18 Whereas, Inequitable distribution of resources and disproportionate negative health outcomes
19 are closely associated, such that socioeconomic variables in a community can predict low voter
20 turnout, including but not limited to demographics, household income, age, and residential
21 mobility^{6,11}; and
22

23 Whereas, Overt and covert methods have been used for voter suppression, especially against
24 historically marginalized populations. The National Conference of State Legislatures found that
25 almost 70% of states require some form of state identification in order to vote which has been
26 shown to be a barrier among African Americans, the poor, and youth. Non-White voter turnout is
27 less restricted in states with strict voter ID laws, demonstrated by the decrease in voter turnout
28 for primary elections specifically in non-White populations following their implementation^{4,14}; and
29

30 Whereas, In the 2016 elections the majority of voters were non-Hispanic, White females aged
31 45-65, with a family income of \$100,000 or more¹⁵; and
32

33 Whereas, In the election of 2020, White voter turnout was 70.9%, significantly more than the
34 58.4% of non-White voters who made it to the polls; demonstrating that barriers to voting in a
35 global pandemic still disproportionately affect non-White voters more¹⁶; and
36

37 Whereas, Communities that have been historically and are currently excluded on the basis of
38 race and socioeconomic status experience significantly more barriers to voter participation,
39 which perpetuated for generations and correlate with rates of health insurance coverage among
40 these groups. National data from multivariate analyses on voter participation and social

determinants of health demonstrate that a lack of medical insurance is significantly correlated with decreased likelihood of voting. In a study on two major US cities demonstrating this trend, it was found that individuals with any insurance had an overall voter participation of 24%, compared to 3% in those that were uninsured¹⁷; and

Whereas, in 2010 the Patient Protection and Affordable Care Act was implemented to increase the number of Americans with health insurance and substantially decrease healthcare associated costs. In 2012, the supreme court declared that the expansion of Medicaid, one of the goals of the Affordable Care Act, would be optional for individual states despite the provision of funding for this expansion¹⁸; and

Whereas, Today there are 12 remaining states that have chosen not to expand Medicaid despite overwhelming support for Medicaid expansion and the federal funding available to do so. Many of these states have utilized gerrymandering as a means to modify the evidence of public opinion and manipulate the voice of the people¹⁹; and

Whereas, Those without health insurance are more likely to support government healthcare programs, yet in the 2016 presidential election, voter turnout for uninsured Americans was 34%²⁰; and

Whereas, almost 40% of the voting-eligible American population did not vote in 2015, with significant gaps in voter turnout existing along racial, educational, and income-level lines, largely attributable to voting restrictions and feelings of alienation from the government⁷; and

Whereas, The relationship between health and voter participation perpetuate inequities in health, social, and economic policy, further worsening health disparities. Historical examples of initiatives that increase civic participation and improve health include the women's suffrage movement which led to an increase in funding for women's health programming and a decrease in child mortality by eight to 15% . Another example exists in the removal of literacy tests in 1965, which expanded the number of Black voters, increasing government funding to areas with larger Black populations and shifting voting patterns within these communities^{4,7,8,14,16, 21-24}; and

Whereas, Voting between the ages of 18-24 is associated with fewer risky health behaviors by instilling a sense of self-efficacy and increasing social connectedness. Voting is also correlated with fewer depressive symptoms in adulthood^{8,9}; and

Whereas, Individuals who vote as a form of civic participation self-report a better state of health than those who do not vote as well as those who abstain from voting report a poorer state of health^{19,23}; and

Whereas, Options for interventions that allow voter registration in clinical settings exist and have been successful in registering patients to vote. In a community clinic model, 89% of those who were eligible to vote were registered with clinic-based voter registration^{11-13, 21}; and

Whereas, Between 2006 and 2018, physicians voted approximately 14% less than the general population²⁶; and

Whereas, Additional research must examine the multidimensional impact of promotion of voter registration and civic participation on the longitudinal health outcomes of patients; therefore be it

1 RESOLVED, That our American Medical Association acknowledge voting is a social
2 determinant of health and significantly contributes to the analyses of other social determinants
3 of health as a key metric (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA recognize gerrymandering as a partisan effort that functions in part
6 to limit access to health care, including but not limited to the expansion of comprehensive
7 medical insurance coverage, and negatively impacts health outcomes (New HOD Policy); and
8 be it further
9

10 RESOLVED, That our AMA collaborate with appropriate stakeholders and provide resources to
11 firmly establish a relationship between voter participation and health outcomes. (Directive to
12 Take Action)

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

Received: 05/09/22

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RELEVANT AMA POLICY

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.

2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.

Citation: Res. 18, I-21

Mental Illness and the Right to Vote H-65.971

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

Citation: Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20

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

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

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

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; Reaffirmed: CMS Rep. 5, I-21

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-22)

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: Awareness Campaign for 988 National Suicide Prevention Lifeline

Referred to: Reference Committee D

1 Whereas, The U.S. is experiencing a profound crisis of mental health and well-being, one
2 compounded by the disruption, isolation, and loss experienced during the COVID-19 pandemic;
3 and
4

5 Whereas, For too long many people who are experiencing a mental health crisis have called 9-
6 1-1 and received an inappropriate response from law enforcement or ended up boarding in
7 emergency rooms due to lack of beds and community services; and
8

9 Whereas, This approach may place unnecessary burdens on people in crisis, their families, and
10 the health and justice systems, and deter people from seeking services for fear of police
11 intervention, being detained, and stigmatized; and
12

13 Whereas, Beginning July 16, 2022, a new, easy to remember, three-digit code – 9-8-8 – will be
14 in effect to, if needed, dispatch mobile crisis teams immediately to anyone going through a
15 mental health crisis; and
16

17 Whereas, The goal of 9-8-8 is to have 24/7 crisis call centers and move mental health crises
18 away from police involvement and toward behavioral health specialist involvement; therefore be
19 it
20

21 RESOLVED, That our American Medical Association utilize their existing communications
22 channels to educate the physician community and the public on the new 9-8-8 program.
23 (Directive to Take Action)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-22)

Introduced by: Maryland

Subject: Physician Interventions Addressing Environmental Health and Justice

Referred to: Reference Committee D

1 Whereas, Environmental degradation and climate change are among the greatest global health
2 threats facing our world in the 21st century; and
3

4 Whereas, Fossil fuels that are fueling the climate crisis are also the sources of pollutants that are
5 causing heart disease, lung disease, and cancer; and
6

7 Whereas, The burdens of environmental degradation have historically fallen on communities of
8 color and low-income communities, exposing them to higher environmental risk, characterized by
9 proximity to hazardous waste sites, exposure to air and water pollution, poor and crowded
10 housing quality, and dangerous work environments; and
11

12 Whereas, Communities of color and low-income communities subsequently experience higher
13 incidences of cardiovascular disease, asthma, cancer risk, and mortality; and
14

15 Whereas, As the world's climate changes, vulnerable communities will be exposed to even higher
16 risks of health harm. Ecological changes will result in increased temperature extremes, natural
17 disasters, wildfires, vector-borne disease, sea level rise, food insecurity, and more; and
18

19 Whereas, Environmental justice is closely tied to social determinants of health; thus, interventions
20 to improve public environmental health must be rooted in participatory and distributive justice,
21 prioritizing those currently facing the greatest disadvantage; and
22

23 Whereas, Healthcare costs can be directly tied to the health of our environment, as climate
24 change and environmental pollutants lead to increased hospitalizations and emergency room
25 visits, which are especially expensive and resource-consuming; and
26

27 Whereas, Research suggests that asthma hospitalizations can be decreased with intervention. In
28 2009, there was a sharp decline in asthma hospitalization rates (57%) in two Baltimore zip codes
29 where there was a large reduction in pollution from nearby coal-fired power plants; and
30

31 Whereas, Physicians have a special obligation to participate in climate health advocacy and
32 policy intervention based on an ethical framework of seven criteria: expertise, proximity,
33 effectiveness, low risk or cost, unique role, severity of outcome, and public trust. Physicians have
34 expertise in treating illnesses related to environmental determinants and climate change and are
35 often first responders with proximity to those who require care. Their advocacy poses low risk to
36 themselves, and they can be effective advocates as they have unique medical expertise. By
37 speaking on the severity of the health consequences of climate change, physicians can uphold
38 public trust; and

Whereas, The current AMA policy H-135.938 1) supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report, 2) supports educating the medical community on the health implications of climate change, 3) recognizes the importance of physician involvement in climate policymaking, 4) encourages physicians to assist in educating patients on environmental sustainability, and 5) supports research necessary for evidence-based climate change policy decisions; and

Whereas, The current AMA policy H-135.938 lacks explicit statement of the importance of physician assessment of environmental determinants of health faced by their patients; and, Whereas, physician assessment of environmental determinants will improve patient outcomes and prevent future development and exacerbation of disease, especially for patients from low-income communities or communities of color; and

Whereas, Previous studies have shown great physician interest in environmental health, but a lack of confidence in their ability to take an environmental history. Currently, there is no systematic documentation of environmental risk factors in the medical record and environmental factors are often not specifically investigated and highlighted as a cause of disease; and

Whereas, A survey study of 500 primary care physicians showed that only 27.8% correctly recognized all health effects related to environmental exposures, and those who recognized the importance of the environment were significantly more likely to have knowledge of environmental risk factors related to respiratory disease. Less than one third of physicians provided educational material about environmental and public health to their patients, and those who asked their patients about environmental exposures were significantly more likely to believe that environmental health history is a useful tool to prevent environmental health exposures; therefore be it

RESOLVED, That our American Medical Association amend policy H-135.938, "Global Climate Change and Human Health," by addition to read as follows:

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.

- 1 5. Encourages physicians to work with local and state health departments to
- 2 strengthen the public health infrastructure to ensure that the global health effects of
- 3 climate change can be anticipated and responded to more efficiently, and that the
- 4 AMA's Center for Public Health Preparedness and Disaster Response assist in this
- 5 effort.
- 6 6. Supports epidemiological, translational, clinical and basic science research
- 7 necessary for evidence-based global climate change policy decisions related to
- 8 health care and treatment.
- 9 7. Encourages physicians to assess for environmental determinants of health in
- 10 patient history-taking and encourages the incorporation of assessment for
- 11 environmental determinants of health in patient history-taking into physician
- 12 training. (Modify Current HOD Policy)

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

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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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-22)

Introduced by: Melissa Garretson, MD, Delegate
Samantha Rosman, MD, MPH, Delegate

Subject: Mental Health Crisis

Referred to: Reference Committee D

1 Whereas, Suicide is the second leading cause of death in youths aged 10-24 years old; and

2
3 Whereas, Patients, including children, suffering from mental health emergencies are boarding in
4 emergency departments at unprecedented rates awaiting inpatient psychiatric admission; and

5
6 Whereas, Societal misperception of mental health disease and lack of adequate payment for
7 mental health services have further contributed to difficulties accessing psychiatric services in
8 multiple settings; and

9
10 Whereas, Validated, evidence based suicide screening tools exist and as these tools are being
11 administered in schools and health care settings additional at risk individuals are being identified
12 and often referred to emergency departments for further evaluation; and

13
14 Whereas, Current suicide prevention interventions are often patchworked across communities
15 and states, and mental health services remain difficult to access despite long term efforts from
16 organized medicine to assure payment parity for mental healthcare; therefore be it

17
18 RESOLVED, That our American Medical Association work expediently with all interested
19 national medical organizations, national mental health organizations, and appropriate federal
20 government entities to convene a federally-sponsored blue ribbon panel and develop a widely
21 disseminated report on mental health treatment availability and suicide prevention in order to:

22
23 1) Improve suicide prevention efforts, through support, payment and insurance coverage for
24 mental and behavioral health and suicide prevention services, including, but not limited to, the
25 National Suicide Prevention Lifeline;

26 2) Increase access to affordable and effective mental health care through expanding and
27 diversifying the mental and behavioral health workforce;

28 3) Expand research into the disparities in youth suicide prevention;

29 4) Address disparities in suicide risk and rate through education, policies and development of
30 suicide prevention programs that are culturally and linguistically appropriate;

31 5) Develop and support resources and programs that foster and strengthen healthy mental
32 health development; and

33 6) Develop best practices for minimizing emergency department delays in obtaining appropriate
34 mental health care for patients who are in mental health crisis. (Directive to Take Action)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-22)

Introduced by: Michigan

Subject: Mental Health First Aid Training

Referred to: Reference Committee D

1 Whereas, Mental Health First Aid (MHFA) is a course that teaches the identification,
2 understanding, and appropriate response to signs of mental illnesses and substance use
3 disorders, providing the skills needed to reach out and provide initial help and support persons
4 who may be developing a mental health or substance use problem or experiencing a crisis; and
5

6 Whereas, There are an estimated 46.6 million adults (about 1 in 5 Americans aged 18 or older)
7 with a mental illness, and more than 20 percent (about 1 in 5) of children have had a seriously
8 debilitating mental disorder; and
9

10 Whereas, Suicide is the tenth leading cause of death overall in the U.S. and the second leading
11 cause of death among people aged 15-34; and
12

13 Whereas, Mood disorders are the third most common cause of hospitalization in the U.S. for
14 youth and adults aged 18-44; and
15

16 Whereas, There are 65.9 million physician office visits with mental disorders as the primary
17 diagnosis annually; and
18

19 Whereas, United Kingdom medical students who underwent the eLearning course of MHFA
20 showcased the potential to improve students' mental health first aid skills and confidence in
21 helping others; and
22

23 Whereas, 27.2 percent of medical students show signs and symptoms of depression and of
24 them, 11.1 percent are suicidal, yet only 16 percent of those screening positive for depression
25 seek psychiatric treatment; and
26

27 Whereas, Online and face-to-face versions of MHFA have shown to improve outcomes for
28 medical and nursing students with mental health problems such as preventing high failure rates
29 and discontinuation of study, and the knowledge from the training was shown to potentially help
30 them with their future careers; and
31

32 Whereas, In a survey of 2,000 U.S. physicians, approximately 50 percent believed they at one
33 point met criteria for a mental health disorder but did not seek treatment; and
34

35 Whereas, MHFA training programs in the U.S. have been shown to increase knowledge of
36 prevalence rates, cardinal signs and symptoms of common mental health diagnoses, and
37 confidence in being able to apply interventional skills; and
38

39 Whereas, In a MHFA pre-survey, health care providers reported the same level of confidence
40 when dealing with mental health as compared to the general public; and

1 Whereas, Current performance in the management of mental illness in primary care settings is
2 described by the rule of diminishing halves: "only half the patients with a threshold disorder are
3 recognized; only half of those recognized are treated; and only half of those treated are
4 effectively treated;" and

5
6 Whereas, A meta-analysis of 90 independent reports demonstrated that mental health
7 intervention programs amongst higher education students showed significant improvement of
8 social-emotional skills, self-perception, and academic and behavior performance, especially
9 when combined with supervised skills practice; and

10
11 Whereas, The number of behavior and mental health-related visits in the Emergency
12 Department (ED) has seen a 44.1 percent increase over the last decade and has now reached
13 an estimated one in every six ED visits; and despite this increase, there still remains a lack of
14 compensatory mental health education to meet the new demand; and

15
16 Whereas, Emergency Medicine (EM) residents care for 1-2 patients per day with psychiatric or
17 behavioral health complaints, yet more than half (55 percent) of them report their perception of
18 involvement to be minimal-to-none in the management and care of these patients (beyond
19 medical clearance), and 84 percent of them report they are more comfortable with treating a
20 patient's physical illness than their mental illness; and

21
22 Whereas, Fifty-nine percent of surveyed EM residents across the U.S. believed that their
23 program should have offered more psychiatric education in order to better equip them with tools
24 about how to handle psychiatric emergencies of all kinds, as only 13 percent reported "well
25 prepared" to do so; and

26
27 Whereas, Rates of mental health disorders are rising, and in many cases, the need far exceeds
28 the resources available; and

29
30 Whereas, The national shortage of psychiatrists is linked to a lack of exposure to clinical
31 psychiatry in medical school curricula; and

32
33 Whereas, Psychiatry enrichment activities in medical school are shown to increase student
34 interest in and understanding of the specialty; and

35
36 Whereas, MHFA has shown to decrease negative attitudes and stigma, and increase supportive
37 behaviors towards people struggling with mental health; and

38
39 Whereas, Mental health education programs for health professionals: general practitioners,
40 psychiatrists, junior medical staff, psychologists, nurses, and social workers, led to an increase
41 in perceived knowledge of mental illness and improvements in attitude toward mental illness;
42 and

43
44 Whereas, Many treatments are available to reduce the symptoms and disabilities of mental
45 illness, yet stigma discourages patients to pursue care as a means to avoid potential
46 discrimination; and

47
48 Whereas, Primary care providers who endorsed stigmatizing ideas surrounding mental illness
49 were found to be less likely to refer patients to needed follow-up services for comorbid physical
50 conditions; and

1 Whereas, First year medical students who received additional mental health education revealed
2 favorable attitudinal changes in terms of psychiatric services, human rights of the mentally ill,
3 patients' independence in social life, and causes and characteristics of mental illness; and
4

5 Whereas, After four years of medical education medical students associated mental illness with
6 stigma, stereotypes, and stress, in contrast to their initial interest in psychiatry before beginning
7 their clinical curriculum; and
8

9 Whereas, A study of fourth year medical students showed that exposure to patients with mental
10 illnesses during psychiatric clerkship did not improve their attitudes towards mental illness and
11 psychiatric conditions as compared to before the clerkship, suggesting more educational
12 training is needed; and
13

14 Whereas, Fourth year medical students who successfully completed their psychiatry clerkship
15 and showed interest in pursuing psychiatry, endorsed that stigma, stereotypes, and stress
16 adversely affected their attitude toward mental illness and willingness to care for patients with
17 mental illness; and
18

19 Whereas, A meta-analysis of randomized controlled trials concerning the incorporation of
20 mental health interventions into higher education showed evidence of long-term sustainability;
21 and
22

23 Whereas, The International Association of Medical Colleges and World Federation for Medical
24 Education require that medical schools incorporate into the curriculum contributions of medical
25 psychology that would enable effective communication, clinical decision-making and ethical
26 practice; and
27

28 Whereas, In the "Mental Health Competencies for Pediatric Practice" Policy Statement, the
29 American Academy of Pediatrics recommends that "pediatricians pursue quality improvement
30 and maintenance of certification activities that enhance their mental health practice, prioritizing
31 suicide prevention" and "advocate for innovations in medical school education, residency and
32 fellowship training, and continuing medical education activities to increase the knowledge base
33 and skill level for future pediatricians in accordance with mental health competencies;" and
34

35 Whereas, The 114th U.S. Congress HR 1877/S711 bill proposes authorization of \$20 million for
36 Mental Health First Aid Training programs to primary care professionals, students, emergency
37 services personnel, police officers, and others with the goal of improving Americans' mental
38 health, reducing stigma around mental illness, and helping people who may be at risk for suicide
39 or self-harm and referring them to appropriate treatment; therefore be it
40

41 RESOLVED, That our American Medical Association support physician acquisition of
42 emergency mental health response skills by promoting education courses for physicians,
43 fellows, residents, and medical students including, but not limited to, mental health first aid
44 training (Directive to Take Action); and be it further
45

46 RESOLVED, That our AMA reaffirm AMA Policy D-345.994 and H-345.984. (Reaffirm HOD
47 Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY**Increasing Detection of Mental Illness and Encouraging Education D-345.994**

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

Citation: Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19

Statement of Principles on Mental Health H-345.999

- (1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
- (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
- (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
- (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.

Citation: A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to

encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

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

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

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

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

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

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

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

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

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

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

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

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

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

Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-22)

Introduced by: Michigan

Subject: Pictorial Health Warnings on Alcoholic Beverages

Referred to: Reference Committee D

1 Whereas, Excessive alcohol use is responsible for more than 95,000 deaths annually, making it
2 a leading cause of preventable death in the U.S., and
3

4 Whereas, More than half of alcohol related deaths are linked to a rising number of life-
5 threatening medical conditions, such as liver cirrhosis, cancer, cardiovascular disease, and
6 stroke with prolonged use of excessive alcohol linked to dementia and neuropathy, and use of
7 excessive alcohol during pregnancy linked to fetal alcohol syndrome, the leading cause of
8 intellectual disability in the U.S., and
9

10 Whereas, Nationally, excessive alcohol use leads to a shortened lifespan by approximately 29
11 years, for a total of 2.8 million years of potential life lost, and
12

13 Whereas, The economic burden of alcohol misuse is significant, costing the U.S. \$249 billion in
14 2010 alone of which, three-quarters of the total cost was related to binge drinking, and
15

16 Whereas, In 2018, 5.8 percent of adults ages 18 and older nationally had alcohol use disorder,
17 26.45 percent of people ages 18 or older reported that they engaged in binge drinking in the
18 past month, and 6.6 percent reported that they engaged in heavy alcohol use in the past month,
19 and
20

21 Whereas, Binge drinking specifically is responsible for more than half the deaths and two-thirds
22 of the years of potential life lost, and
23

24 Whereas, These numbers remain so despite a congressional "Alcoholic Beverage Labeling Act"
25 (ABLA) passed in 1988 requiring health warning statements in text to appear on the labels of all
26 containers of alcohol beverages for sale or distribution in the U.S., and
27

28 Whereas, Only 35 percent of all adults in the summer of 1991 reported having seen the warning
29 label, signifying that these labels have done little to reduce rates of alcohol-related risky
30 behaviors, rates of consumption, or alcohol-related poor health outcomes during this period, and
31

32 Whereas, From 1988-1995, studies repeatedly showed that (1) larger pictorial and symbolic
33 health warnings on tobacco packaging were both more effective at reducing tobacco use than
34 smaller text-only warnings and (2) a mixture of health-related and social-related graphic health
35 warnings on tobacco packaging were most effective at reducing tobacco use, and
36

37 Whereas, Experts have recommended, and studies have shown that the use of pictorial health
38 warnings on alcoholic beverages lead to improve health outcomes, and

1 Whereas, In the past decade several studies have predicted and proven that negative pictorial
2 health warnings are associated with significantly increased perceptions of the health risks of
3 consuming alcohol as well as greater intentions to reduce and quit alcohol consumption
4 compared to the control, and

5
6 Whereas, Though critics cite the somatic benefits of alcohol in moderation and question the
7 need for health warnings on alcoholic beverages, research shows that there are adverse effects
8 related to cancer at any level of alcohol consumption, and

9
10 Whereas, Critics argue that alcohol can still be consumed in bars and pubs without drinkers
11 seeing the packaging, research actually shows that alcohol purchased from supermarkets is
12 more than twice the level of alcohol consumed in bars and pubs; therefore be it

13
14 RESOLVED, That our AMA amend Policy H-30.940, "AMA Policy Consolidation: Labeling
15 Advertising, and Promotion of Alcoholic Beverages," by addition to read as follows:

16
17 AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages
18 H-30.940

19 (1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all
20 beverages, including so-called "nonalcoholic" beer and other substances as well,
21 including over-the-counter and prescription medications, with removal of "nonalcoholic"
22 from the label of any substance containing any alcohol; (b) supports efforts to educate
23 the public and consumers about the alcohol content of so-called "nonalcoholic"
24 beverages and other substances, including medications, especially as related to
25 consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and
26 Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject
27 proposals by the alcoholic beverage industry for authorization to place beneficial health
28 claims for its products on container labels; and (d) urges the development of federal
29 legislation to require nutritional labels on alcoholic beverages in accordance with the
30 Nutritional Labeling and Education Act.

31 (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by
32 persons under 21 years of age, which creates an image of drinking alcoholic beverages
33 and thereby may encourage the illegal underaged use of alcohol; (b) recommends that
34 health education labels be used on all alcoholic beverage containers and in all alcoholic
35 beverage advertising (with the messages focusing on the hazards
36 of alcohol consumption by specific population groups especially at risk, such as
37 pregnant women, as well as the dangers of irresponsible use to all sectors of the
38 populace); ~~and~~ (c) recommends that the alcohol beverage industry be encouraged to
39 accurately label all product containers as to ingredients, preservatives, and ethanol
40 content (by percent, rather than by proof); and (d) advocates that the alcohol beverage
41 industry be required to include pictorial health warnings on alcoholic beverages.

42 (3.) Actively supports and will work for a total statutory prohibition of advertising of all
43 alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal,
44 our AMA (a) supports continued research, educational, and promotional activities
45 dealing with issues of alcohol advertising and health education to provide more
46 definitive evidence on whether, and in what manner, advertising contributes
47 to alcohol abuse; (b) opposes the use of the radio and television to promote drinking;
48 (c) will work with state and local medical societies to support the elimination of
49 advertising of alcoholic beverages from all mass transit systems; (d) urges college and
50 university authorities to bar alcoholic beverage companies from sponsoring athletic
51 events, music concerts, cultural events, and parties on school campuses, and from
52 advertising their products or their logo in school publications; and (e) urges its

constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA advocate for the implementation of pictorial health warnings on alcoholic beverages. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

Citation: CSA Rep. 1, A-04; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-22)

Introduced by: Medical Student Section

Subject: Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities

Referred to: Reference Committee D

1 Whereas, According to the Americans with Disabilities Act of 1990 (ADA) and The ADA
2 Amendments Act of 2008, disability is defined as “physical or mental impairment that
3 substantially limits one or more major life activities, a person who has a history or record of such
4 an impairment, or a person who is perceived by others as having such an impairment”¹⁻³; and
5

6 Whereas, The World Health Organization defines disability broadly as an “interaction between
7 individuals with a health condition and personal and environmental factors”, which
8 acknowledges the individualistic and contextual nature of disability⁴; and
9

10 Whereas, The disability justice movement recognizes disability (including but not limited to
11 developmental, intellectual, physical, sensory, learning, and psychiatric disability) as a
12 component of diversity and identity that intersects with other forms of diversity and identity
13 (including but not limited to social class, race, age, gender identity, and geographic location)⁵;
14 and
15

16 Whereas, Studies report approximately 12 to 30% of the United States’ population has a
17 disability^{4,6-8}; and
18

19 Whereas, Similar to other oppressed minority groups, people with disabilities have experienced
20 a long-shared history of marginalization and discrimination in society and medicine, and as a
21 result, continue to experience health disparities and social determinants of poor health^{6,8-11};
22 and
23

24 Whereas, Physicians of all specialties will treat patients with a range of disability, yet many
25 physicians hold implicit and explicit biases, such that studies demonstrate that healthcare
26 providers consistently assume a lesser quality of life for people with disabilities than what is self-
27 reported^{5,8-9}; and
28

29 Whereas, In a 2019-2020 survey of United States’ physicians, less than half (40.4%) were
30 confident they could provide the same quality of care for those with a disability, around half
31 (56.5%) strongly agreed that they welcome patients with disability into their practices, and less
32 than one fifth (18.1%) strongly agreed that the healthcare system often treats these patients
33 unfairly⁸; and
34

35 Whereas, Research demonstrates that physicians and medical students report a lack of comfort
36 in interviewing and examining patients with disabilities, often translating to poor outcomes and
37 negative attitudes toward working with this population^{5-6,12-19}; and

1 Whereas, Disability curricula in undergraduate medical education is highly variable, such that a
2 2015 survey estimated that less than 23% of medical schools provide any disability-focused
3 training^{5,19-20}; and
4

5 Whereas, Even though disability core competencies and curricula exist at some institutions, no
6 standardized disability curriculum currently exists across undergraduate medical education or
7 graduate medical education^{5,21}; and
8

9 Whereas, The Liaison Committee on Medical Education and the Accreditation Council for
10 Graduate Medical Education do not require disability training curricula as an accreditation
11 requirement for undergraduate medical education or graduate medical education programs
12 respectively²²⁻²³; and
13

14 Whereas, Major reports, most notably the Surgeon General's 2005 "Call to Action", the Institute
15 of Medicine's 2007 "The Future of Disability in America", and the National Council on Disability's
16 2015 "The Current State of Health Care for People with Disabilities", all call for improvements in
17 the training of healthcare providers in order to address health disparities for people with
18 disabilities^{1,3-4,6,9,24-28}; and
19

20 Whereas, Section 5307 of the Patient Protection and Affordable Care Act specifically requires
21 the development, evaluation, and dissemination of disability cultural competency curricula for
22 training in health professions schools and continuing education programs^{19,29}; and
23

24 Whereas, Disability studies scholars and activists advocate for disability-conscious medical
25 education, training, and practice that includes critical disability studies, a multidisciplinary
26 academic field which "explores the social, political, and cultural contexts of disability"^{5,12,31}; and
27

28 Whereas, Several medical schools have created and evaluated model disability curricula and
29 the Alliance for Disability in Health Care Education has developed disability competencies that
30 could provide a framework for implementing disability curricula at other institutions^{22,32-34}; and
31

32 Whereas, Research demonstrates that disability curricula are well-received by students, reduce
33 bias, and improve health professionals' confidence with working with patients with disabilities<sup>35-
34 36</sup>; and
35

36 Whereas, Research demonstrates that incorporation of people with disabilities as patient-
37 instructors, or standardized patients, is beneficial to student learning and addresses the harmful
38 reduction of people to their disabilities that may result from a non-disabled actor playing a
39 role^{33,37-40}; and
40

41 Whereas, These changes are even more urgent since the COVID-19 pandemic has further
42 exposed ableism in medicine and continues to exacerbate the health disparities experienced by
43 people with disabilities^{5,8}; and
44

45 Whereas, While AMA policy "A Study to Evaluate Barriers to Medical Education for Trainees
46 with Disabilities D-295.929" has the potential to revise technical standards and remove outdated
47 standards rooted in bias, it only addresses the need to expand inclusion of people with
48 disabilities within medical education, training, and practice, but does not go far enough to
49 include care and treatment outlined in curricula and continuing education; and
50

51 Whereas, While AMA policy "Medical Care of Persons with Developmental Disabilities
52 H-90.968" advocates for medical curricula involving the care and treatment of those with

developmental disabilities, it is too narrow in its definition of disability to address the lack of training that contributes to salient health inequities for an extremely diverse demographic that shares experiences of stigma and discrimination in all arenas of public life; therefore be it

RESOLVED, That, in order to address the shared healthcare barriers of people with disabilities and the need for curricula in medical education on the care and treatment of people with a range of disabilities, our American Medical Association amend by addition and deletion H-90.968 "Medical Care of Persons with Developmental Disabilities" to include those with a broad range of disabilities while retaining goals specific to the needs of those with developmental disabilities:

Medical Care of Persons with ~~Developmental~~ Disabilities, H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with ~~developmental~~ disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with ~~Developmental~~ Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for ~~quality~~, developmentally appropriate and accessible medical, social and living support for patients with ~~developmental~~ disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound ~~developmental~~ disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the ~~developmentally~~ disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with ~~developmental~~ disabilities to implement priorities and quality improvements for the care of persons with ~~developmental~~ disabilities.

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with ~~intellectual disabilities/developmentally disabled individuals~~, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with ~~intellectual disabilities/developmentally disabled individuals~~.

3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with ~~developmental~~ disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound ~~developmental~~ disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound ~~developmental~~ disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound ~~developmental~~ disabilities, that there are resources available to them.

~~4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school~~

curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of developmental disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

(Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
 3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
 4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
 5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
 6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
 7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
 9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.
 10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.
- CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

Children and Youth with Disabilities H-60.974

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

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

Support for Persons with Intellectual Disabilities H-90.967

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Res. 01, A-16

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18

Promoting Health Awareness of Preventative Screenings in Individuals with Disabilities H-425.970

Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

Res. 911, I-13

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; (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; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes 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.

Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

Eliminating Use of the Term ‘Mental Retardation’ by Physicians in Clinical Settings H-70.912

Our AMA recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.

Res. 024, A-19

Service Animals, Animal-Assisted Therapy, and Animals in Healthcare H-90.966

Our AMA: (1) encourages research into the use of animal-assisted therapy as a part of a therapeutic treatment plan; (2) supports public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA); (3) supports a national certification program and registry for legitimately trained service animals, as defined by the ADA; and (4) encourages health care facilities to set evidence-based policy guidelines for animal visitation.

BOT Rep. 29, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-22)

Introduced by: Medical Student Section

Subject: Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality

Referred to: Reference Committee D

1 Whereas, The World Health Organization (WHO) urges member states “to identify the most
2 suitable policy approach to reduce the impact on children of marketing of foods high in saturated
3 fats, trans-fatty acids, free sugars, or salt”^{1,2}; and
4

5 Whereas, The Federal Tax Code allows advertising costs to be deducted as a regular business
6 expense for tax purposes and avoid taxation at the corporate tax rate³; and
7

8 Whereas, The American Academy of Pediatrics and American Heart Association recommend
9 changing federal tax law to prohibit food and beverage companies from deducting all or part of
10 the cost of marketing unhealthy products⁴; and
11

12 Whereas, Targeted advertising to children is defined as those advertisements that appear
13 alongside television programs with an audience share of at least 30% for children aged 2–11
14 years or 20% for adolescents aged 12–17 years⁵; and
15

16 Whereas, Television advertising heavily informs children’s food knowledge, preferences,
17 purchase requests, and consumption patterns, and is associated with increased consumption of
18 sugary snacks and beverages, as well as excess calorie intake, and a majority of food-related
19 advertisements viewed by American youth feature primarily unhealthy categories of food⁶⁻⁷; and
20

21 Whereas, The Council of Better Business Bureaus launched the Children’s Food and Beverage
22 Advertising Initiative (CFBAI) in 2006 to create a coalition of food and beverage companies,
23 including 17 of the nation’s largest food companies, pledging to promote healthier foods and
24 beverages, based first on company-defined and then uniform standards; however, there has
25 been no significant improvement in the nutritional quality of foods marketed to children since the
26 CFBAI’s launch, indicating that industry self-regulation is insufficient⁸; and
27

28 Whereas, The Interagency Working Group (IWG) on Food Marketed to Children (with
29 representatives from the Federal Trade Commission, the Centers for Disease Control and
30 Prevention, the Food and Drug Administration, and the United States Department of Agriculture)
31 was established in 2009 to draft “voluntary nutrition principles to guide industry self-regulatory
32 efforts to improve the nutritional profile of foods that are most heavily marketed to children”⁹;
33 and
34

35 Whereas, The IWG recommends that foods and beverages marketed to children should provide
36 a meaningful contribution to a healthful diet and should not surpass certain limits for nutrients,
37 including saturated fat, trans fat, added sugars, and sodium, not counting naturally occurring
38 nutrients⁹; and

1 Whereas, Nearly all products featured in CFBAI company-member advertisements and 80-90%
2 of non-CFBAI company advertisements seen on children's programming are nutritionally poor
3 foods, indicating that IWG guidelines are not being followed³; and
4

5 Whereas, Elimination of tax subsidies for advertisements that promote nutritionally poor foods
6 and beverages among children is considered one of the most cost-effective interventions
7 against childhood obesity^{3,10,11}; and
8

9 Whereas, It is estimated that eliminating the tax subsidy would yield an aggregate decrease of
10 2.14 million BMI units in the population, resulting in a net gain of 4,528 quality-adjusted life
11 years over a 10-year period³; and
12

13 Whereas, "Added sugar" refers to any sugars added to a food product during processing and/or
14 packaging such as artificial sweeteners, syrup, honey, or concentrated fruit and vegetable juices
15 that are not naturally occurring^{12,13}; and
16

17 Whereas, The health impact of excessive consumption of sugar and sugary foods has been well
18 documented over the last 20 years, with numerous studies showing that overconsumption is
19 linked to obesity, cardiovascular disease, and diabetes^{14,15}; and
20

21 Whereas, Heavily processed foods, which are higher in added sugars, are easier to mass
22 produce and distribute and have longer shelf lives, making them more viable options in low-
23 income areas, and processed foods are disproportionately marketed towards lower income
24 communities and communities of color¹⁶; and
25

26 Whereas, Studies on the Berkeley California SSB tax show that the consumption of cheaper
27 untaxed products increased while taxed SSB consumption decreased, while overall consumer
28 spending per visit did not, indicating consumers were able to shift to other foods after the tax¹⁷;
29 and
30

31 Whereas, Hungary and Mexico introduced taxes on items with unhealthy levels of sodium,
32 sugar, or unhealthy saturated fats; in Mexico, within one year there was a 12% reduction in
33 purchases of taxed products, with the reduction reaching as high as 17% in lower
34 socioeconomic brackets, and these results were sustained over time; in Hungary, a 27%
35 reduction in sales tax affected products was observed after implementation of the tax, and it
36 was found that manufacturers were entirely removing or greatly decreasing added sugars in
37 response¹⁸⁻²⁰; and
38

39 Whereas, There is precedent for directing revenue from sugar taxes back toward improving
40 nutrition in communities, to avoid these taxes harming lower socioeconomic status communities,
41 as the Berkely SSB tax yielded over \$1.4M in tax revenue its first year that was allocated for
42 child nutrition and community health programs; further, the Sugar Drinks Tax Act of 2021
43 (SWEET Act), introduced into the U.S. House of Representatives on April 21st, 2021, would
44 direct revenue would be used to support the School Breakfast Program, a state-run breakfast
45 programs in schools and residential childcare institutions^{17,21,22}; and
46

47 Whereas, Our AMA supports taxes on SSBs to reduce their consumption (H-150.927), but has
48 not addressed the equally important issue of food products with added sugars; therefore be it

1 RESOLVED, That our American Medical Association advocate for the end of tax subsidies for
2 advertisements that promote among children the consumption of food and drink of poor
3 nutritional quality, as defined by appropriate nutritional guiding principles (Directive to Take
4 Action); and be it further

5
6 RESOLVED, That our AMA amend H-150.927, "Strategies to Reduce the Consumption of
7 Beverages with Added Sweeteners" by addition to read as follows:
8

9 H-150.927 – STRATEGIES TO REDUCE THE CONSUMPTION OF FOOD AND
10 BEVERAGES WITH ADDED SWEETENERS

11 Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened
12 beverage (SSB) consumption and food products with added sugars, and support
13 evidence-based strategies to reduce the consumption of SSBs and food products with
14 added sugars, including but not limited to, excise taxes on SSBs and food products
15 with added sugars, removing options to purchase SSBs and food products with added
16 sugars in primary and secondary schools, the use of warning labels to inform
17 consumers about the health consequences of SSB consumption and food products
18 with added sugars, and the use of plain packaging; (2) encourages continued
19 research into strategies that may be effective in limiting SSB consumption and food
20 products with added sugars, such as controlling portion sizes; limiting options to
21 purchase or access SSBs and food products with added sugars in early childcare
22 settings, workplaces, and public venues; restrictions on marketing SSBs and food
23 products with added sugars to children; and changes to the agricultural subsidies
24 system; (3) encourages hospitals and medical facilities to offer healthier beverages,
25 such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of
26 SSBs and apply calorie counts for beverages in vending machines to be visible next
27 to the price; ~~and~~ (4) encourages physicians to (a) counsel their patients about the
28 health consequences of SSB consumption and food products with added sugars and
29 replacing SSBs and food products with added sugars with healthier beverage and
30 food choices, as recommended by professional society clinical guidelines; and (b)
31 work with local school districts to promote healthy beverage and food choices for
32 students; and (5) recommends that taxes on food and beverage products with added
33 sugars be enacted in such a way that the economic burden is borne by companies
34 and not by individuals and families with limited access to food alternatives; and (6)
35 supports that any excise taxes are reinvested in community programs promoting
36 health. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Television Commercials Aimed at Children H-485.998

Our AMA opposes TV advertising and programming aimed specifically at exploiting children, particularly those ads and programs that have an impact on the health and safety of children.

Res. 27, A-79; Reaffirmed: CLRPD Rep. B, I-89; Sub. Res. 220, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-12

Obesity as a Major Public Health Problem H-150.953

Our AMA will: (1) urge physicians as well as managed care organizations and other third-party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

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

Obesity as a Major Health Concern H-440.902

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

Res. 423, A-98; 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

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-13

Nutrition Education H-150.996

Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools.

Sub. Res. 66, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CME Rep. 01, A-17

Quality of School Lunch Program H-150.962

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

2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17; Appended: Res. 217, A-21

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

CSAPH Rep. 03, A-17

Taxes on Beverages with Added Sweeteners H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
 2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
 3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.
 4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.
- CSAPH Rep. 5, A-12, Reaffirmation A-13, Reaffirmed: CSAPH Rep. 03, A-17, Appended: Res. 414, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-22)

Introduced by: Medical Student Section

Subject: Longitudinal Capacity-Building to Address Climate Action and Justice

Referred to: Reference Committee D

1 Whereas, The most recent report of the Intergovernmental Panel on Climate Change (IPCC)
2 found that “human-induced climate change is already affecting many weather and climate
3 extremes in every region across the globe”¹; and
4

5 Whereas, The first installment of the IPCC’s Sixth Assessment Report observed that “global
6 surface temperature will continue to increase until at least the mid-century under all emissions
7 scenarios considered,” and “global warming of 1.5°C and 2°C will be exceeded during the 21st
8 century unless deep reductions in CO₂ and other greenhouse gas emissions occur in the
9 coming decades”¹; and
10

11 Whereas, Limiting global warming to 1.5°C is dependent upon reaching net zero carbon dioxide
12 emissions globally by around year 2050, as well as a significant reduction in non-carbon dioxide
13 drivers¹; and
14

15 Whereas, The deleterious health implications of climate change are well-characterized and
16 range from heat-related illness and death to vector-borne diseases to food- and water-borne
17 illnesses^{2,3}; and
18

19 Whereas, Between 2000 and 2017, there were 158 hospital evacuations in the United States,
20 55.2% of which required the evacuation of more than 100 patients, and 72.2% of these
21 evacuations were due to natural, climate-sensitive events such as hurricanes (65 evacuations),
22 wildfires (21 evacuations), floods (10 evacuations), and storms (8 evacuations)^{4,5}; and
23

24 Whereas, Extreme weather events precipitated and exacerbated by climate change have
25 myriad negative repercussions for the healthcare system, such as causing health facility
26 damage and closures, transportation disruptions, power outages, displacement of health
27 professionals, supply chain disruptions, and overcrowding of hospitals^{5,6}; and
28

29 Whereas, The detrimental effects caused by climate change are inequitably distributed and
30 disproportionately borne by marginalized and minoritized populations due to more substantial
31 exposures and less capacity to mitigate the dangers of global warming^{7,8}; and
32

33 Whereas, Inequities in access to healthcare, transportation infrastructure, energy production
34 resources, and spending on climate mitigation and resilience measures drive the disparate
35 impacts of climate change on vulnerable communities, resulting in reduced capacity to respond
36 to its dangerous effects⁷⁻¹²; and
37

38 Whereas, Older adults, Black and Indigenous populations, people with chronic illnesses or
39 mobility challenges, geographically isolated communities, socioeconomically disadvantaged
40 populations including low-income countries, and children are particularly vulnerable to poorer

1 health outcomes due to the harmful impacts of climate change, and children will suffer the
2 longest exposures to these effects^{3,7,10,12,13}; and

3
4 Whereas, Climate justice has been defined as “a local, national, and global movement to protect
5 at-risk populations who are disproportionately affected by climate change,” recognizing that
6 there are grave disparities between the communities most responsible for generating its
7 destructive repercussions and those most burdened by its adverse effects^{10,12,13}; and

8
9 Whereas, Heat-related mortality, including deaths from heat stress, heatstroke, and heat-related
10 exacerbations of cardiovascular and respiratory disease, in people older than 65 years has
11 increased by 53.7% in the past 20 years (resulting in 296,000 deaths in 2018), and people with
12 disabilities and pre-existing medical conditions are most likely to be impacted⁸; and

13
14 Whereas, Rising temperatures endanger the global food supply, with the global yield potential
15 for major crops such as maize, winter wheat, soybean, and rice decreasing from 1981 to 2019
16 by 1.8-5.6%, intensifying under-nourishment and malnutrition with the most significant impacts
17 on low- and middle-income countries already suffering from high rates of food insecurity⁸; and

18
19 Whereas, The United States healthcare system is a major contributor to greenhouse gas
20 emissions and its injurious impact on the climate is escalating, with emissions derived from the
21 United States health sector increasing by six percent from 2010 to 2018, when the greenhouse
22 gas and toxic air pollutant emissions from the health system caused the loss of 388,000
23 disability-adjusted life-years¹⁴; and

24
25 Whereas, The healthcare sector is responsible for 4.4% of global greenhouse gas emissions,
26 emitting 2 billion metric tons of carbon dioxide equivalent annually as of 2014, and the United
27 States produces both the highest rate of emissions from its healthcare system (7.6% of its total
28 climate footprint) and the highest total contribution to emissions (546 million metric tons of
29 carbon dioxide equivalent)¹⁵; and

30
31 Whereas, In 2018, greenhouse gas emissions from the healthcare supply chain comprised over
32 80% of the emissions from the United States healthcare sector, representing 453 million metric
33 tons of carbon dioxide equivalent, and electric power generation, transmission, and distribution
34 produced 29.4% of greenhouse gas emissions from the United States healthcare system¹⁴; and

35
36 Whereas, The United States healthcare sector has the highest per capita greenhouse gas
37 emissions of any country worldwide, at 1,693 kilograms of carbon dioxide equivalent per
38 capita¹⁴; and

39
40 Whereas, Because of the significant contributions of the healthcare sector to global greenhouse
41 gas emissions, the decarbonization of the healthcare system constitutes an imperative to reach
42 net zero emissions by 2050 and improve global health equity^{14,15}; and

43
44 Whereas, As noted in the 2020 report of the *Lancet* countdown on health and climate change,
45 “Doctors, nurses, and the broader profession have a central role in health system adaptation
46 and mitigation, in understanding and maximizing the health benefits of any intervention, and in
47 communicating the need for an accelerated response”⁸; and

48
49 Whereas, Extant AMA policy “concurs with the scientific consensus that the Earth is undergoing
50 adverse global climate change and that anthropogenic contributions are significant” (H-
51 135.938), “urges Congress to adopt a comprehensive, integrated natural resource and energy
52 utilization policy that will promote more efficient fuel use and energy production” (H-135.977),

and “supports initiatives to promote environmental sustainability and other efforts to halt global climate change” (H-135.923); and

Whereas, The AMA has committed to exploring environmentally sustainable practices for the distribution of the *Journal of the American Medical Association* (D-135.968) and moving “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” (D-135.969); and

Whereas, The AMA currently lacks the organizational capacity to engage in health-oriented climate advocacy that meets the scale of the global climate crisis; therefore be it

RESOLVED, That our American Medical Association: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for prompt passage of legislation and policies that limit global warming to no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the House of Delegates. (Directive to Take Action)

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

Received: 05/11/22

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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.

CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change - The "Greenhouse Effect" H-135.977

- Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968

Our AMA will continue to explore environmentally sustainable practices for JAMA distribution.

BOT Rep. 8, 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.

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.

BOT Rep. 34, A-18

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.

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

Climate Change Education Across the Medical Education Continuum H-135.919

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

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA opposes legislation to weaken the existing provisions of the Clean Air Act.
Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11; Modified: CSAPH Rep. 1, A-21

Environmental Protection and Safety in Federal Facilities H-135.985

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments.

BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

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.

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

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.

Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14; Modified: Res. 521, A-18

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956

The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries.

Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation I-16

Assurance and Accountability for EPA's State Level Agencies H-135.924

Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

Res. 221, A-16

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.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Synthetic Gasification D-135.977

Our AMA will encourage the study the health effects of clean coal technologies including synthetic gasification plants.

Res. 514, A-12

Air Pollution and Public Health D-135.985

Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.

Res. 408, A-08; Reaffirmation A-14

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

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.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

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.

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

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. 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

Protecting Public Health from Natural Gas Infrastructure H-135.930

Our AMA recognizes the potential impact on human health associated with natural gas infrastructure and supports legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.

Res. 519, A-15

Support Reduction of Carbon Dioxide Emissions D-135.972

Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.

Res. 421, A-14; Modified: Res. 506, A-15

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.

Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

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.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-22)

Introduced by: Medical Student Section

Subject: Protections for Incarcerated Mothers and Infants in the Perinatal Period

Referred to: Reference Committee D

Disclaimer: We acknowledge that not all persons who give birth are women or prefer the term “mother”, and that the following applies to all individuals who may give birth, regardless of gender.

Data Collection on Pregnancy While Incarcerated

Whereas, Since the 1980’s females (those assigned female at birth) have been the fastest-growing segment of the incarcerated population, and in 2019, there were 218,000 females incarcerated in prisons and jails within the United States comprising about 10% of incarcerated individuals¹⁻³; and

Whereas, Three out of four incarcerated females in the United States are of childbearing age and already mothers, and up to 80% of incarcerated females report being heterosexually active without consistent contraceptive methods prior to being arrested, and this can lead to being pregnant before entering incarceration^{2,4}; and

Whereas, In 2016 a survey of 22 state prisons found 3.8% of new admissions were pregnant people, and in a similar survey conducted at U.S. jails, 3% of admissions were pregnant people, which suggest a national jail admission rate of pregnant people to be around 55,000 a year^{4,5}; and

Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people despite the high frequency of pre-existing health conditions in incarcerated populations and the established relationship between incarceration and exacerbation of pre-existing medical conditions⁶⁻⁹; and

Whereas, State and federal Maternal Mortality Review Committees and the CDC’s surveillance reports on maternal mortality and morbidity use data from surveillance of perinatal outcomes to improve understanding of disparities among racial groups and inform the development of policies and initiatives aimed at meeting the needs of high-risk populations, but data on incarceration status is not included in this surveillance⁸⁻²⁰; and

Whereas, Quality improvement research can improve care for vulnerable populations, and data from surveillance of perinatal outcomes and studies regarding the accessibility and quality of healthcare available to pregnant incarcerated people would expand the current knowledge of disparities within this particularly vulnerable group²¹⁻²⁴; and

Whereas, There are currently no standard methodologies or requirements for collecting data on incarcerated pregnant people and, prior to 2016, had been no organized review of pregnancy outcomes of incarcerated people in the United States²⁵; and

1 Whereas, Incarcerated pregnant people are often deprived of prenatal care, adequate nutrition,
2 access to appropriate accommodations, and timely medical care, all of which are known to
3 contribute to poor health outcomes^{7,8,26-31}; and
4

5 Whereas, The American College of Obstetricians and Gynecologists (ACOG) has established
6 guidelines on prenatal and postnatal care for incarcerated women, including assessing
7 pregnancy risk, providing medication-assisted treatment for opioid use disorder in pregnant
8 people, and avoiding the use of restraints on people who are pregnant or within six weeks of
9 postpartum, but data show that many incarcerated women do not receive care in accordance
10 with these guidelines^{8,25,32}; and
11

12 Whereas, Only a small number of states, including Pennsylvania, North Carolina, and
13 Oklahoma, have explicit standards of care for incarcerated pregnant mothers, such as specific
14 lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk
15 pregnancies³³⁻³⁵; and
16

17 Whereas, The US Government Accountability Office reported in 2021 that the US Marshals
18 Service and Bureau of Prisons' Detention Standards and Policies either do not align or only
19 partially align with national guidance recommendations on the treatment and care of pregnant
20 people, and the US Bureau of Prisons and most state correctional facilities do not require
21 specific or explicit guidelines for perinatal care or nutrition^{36,37}; and
22

23 Separation of Infants and Postpartum People in Incarceration

24

25 Whereas, In the US, when a pregnant person gives birth while incarcerated, the infant is often
26 separated from the parent soon after birth to be placed in kinship care, foster care, or given up
27 for adoption, which can lead to the termination of parental rights³⁸; and
28

29 Whereas, The United States is one of only four nations which routinely separate infants from
30 postpartum pregnant people, and many other nations including the United Kingdom and Canada
31 offer Mother-Baby Units in prisons or jails to keep infants with their caregiver for a given period
32 of time³⁹; and
33

34 Whereas, In United Nations Children's Fund (UNICEF) report *Implementation Handbook for the*
35 *Convention on the Rights of the Child* 3rd edition, UNICEF states that children should not be
36 separated from their mother due to incarceration because of the child's wellbeing and right to
37 family life and that if the mother is incarcerated the infant should be present in the prison or jail if
38 possible³⁸; and
39

40 Whereas, Separation of infants from pregnant persons post-partum can have negative effects
41 for the baby, including altered heart rate, impaired infant-parent bonding, lower rates of
42 successful breastfeeding, and impaired social and emotional development, as well as negatively
43 affected parental well-being⁴⁰⁻⁴⁴; and
44

45 Whereas, The immediate separation of newborns from their parent during the postpartum period
46 is associated with long-lasting deficits in maternal feelings of competency, infant self-regulation,
47 and the mother-infant relationship, while interventions that enhance mother-infant contact are
48 associated with short- and long-term improved neurodevelopmental and behavioral outcomes in
49 newborns and children⁴³; and

Whereas, The American College of Obstetricians and Gynecologists opposes the policy of immediate separation of infants from pregnant persons postpartum, stating that people who give birth while incarcerated should be allowed the maximum time for parent-infant bonding and further that immediately separating infants from incarcerated parents for non-medical reasons is unnecessary, punitive, and harmful⁴⁰; and

Whereas, Eleven states offer alternatives to immediate separation, such as prison nursery programs, which is a living arrangement located within a correctional facility in which an imprisoned parent and their infant can consistently co-reside with the parent as the primary caregiver during some or all of the mother's sentence^{44,45}; and

Whereas, Alternatives to immediate separation, like prison nursery programs, have been shown to potentially increase infant-parent attachment and bonding, reduce recidivism, and improve parents' self-esteem and child rearing skills^{44,45}; and

Whereas, In May 2021, Minnesota became the first state to oppose the immediate separation of infants from incarcerated pregnant people through passing the Healthy Start Act, which allowed incarcerated pregnant people to be placed in community-based programs such as halfway houses during the late term of their pregnancy and up to one year after⁴⁶; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a baby's life^{47,48}; and

Breastfeeding in Incarceration

Whereas, Breast milk has established benefits for the baby, including reduced risks of infection, such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established benefits of breastfeeding and breast milk expression for the mother, including reduced risk of breast and ovarian cancer, type 2 diabetes mellitus, and hypertension⁴⁷⁻⁵⁰; and

Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities, increased brain development in children, and improved mother-child relationship⁵¹; and

Whereas, The cost of infant formula is up to \$1,500 per year; alternatively, feeding a baby with pasteurized donor human milk costs an average of \$4.50 per ounce, and further, the cost of healthcare in a breastfed baby's first year of life is, on average, \$331 less than a formula-fed baby⁵²⁻⁵⁶; and

Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the health of both the mother and infant⁵⁷; and

Whereas, A woman's right to breastfeed or express breast milk in any private or public location is protected by law in all 50 states of the United States; however, for mothers in prison, there are significant barriers to expressing and storing breast milk, such as requiring presence of a prison guard, time restrictions, and insufficient equipment^{58,59}; and

Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while incarcerated will decrease their milk supply, hindering their ability to directly breastfeed⁶⁰; and

Whereas, In 2017, the National Commission on Correctional Health Care called on correctional facilities to support programs for incarcerated women to breastfeed their babies directly or pump breast milk and store it for later delivery to the infant⁶¹; and

Whereas, The protections for incarcerated mothers to express milk may be established on a state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington have laws offering protections, although still with limitations^{58,62-67}; and

Whereas, Our AMA supports initiatives to promote early intervention for healthcare needs of children with incarcerated parents (H-60.903) and has supported research on bonding programs for women prisoners and their newborn children (H-430.990) since 1997, but does not oppose the separation of infants and postpartum people; and

Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated individuals (D-430.997, H-430.986, H-430.997) and has supported standards to improve the safety of pregnant incarcerated people (H-420.957), and our AMA has policies in support of breastfeeding (H-245.982), though these policies do not specify protecting an incarcerated mother's right to express milk; therefore be it

RESOLVED, That our American Medical Association encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose the immediate separation of infants from incarcerated pregnant individuals post-partum; (Directive to Take Action) and be it further

RESOLVED, That our AMA support solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

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

Res. 440, A-04; Amended: BOT Action in response to referred for decision; Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-

entry into the community.

2. Our AMA advocates and requires a smooth transition including 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. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. 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 use 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.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Reaffirmed: Res. 229, A-21

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

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 Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate Resolution RS-056 (I-20) Page 5 of 6 medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12;

Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended:

Res. 906, I-17; Reaffirmation: I-18

Children of Incarcerated Parents H-60.903

Our AMA supports comprehensive evidence-based care, legislation, and initiatives that address the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk.

Res. 503, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-22)

Introduced by: Medical Student Section

Subject: Recognizing Loneliness as a Public Health Issue

Referred to: Reference Committee D

1 Whereas, Loneliness is defined as “the discrepancy between a person’s preferred and actual
2 level of social contact,”¹; and

3
4 Whereas, Social isolation is defined as “an objective state of having minimal social contact with
5 other individuals”¹; and

6
7 Whereas, The World Health Organization lists “social support networks” as a determinant of
8 health²; and

9
10 Whereas, The 2018 Cigna U.S. Loneliness Index found that nearly half of U.S. adults report
11 sometimes or always feeling lonely³; and

12
13 Whereas, Younger generations are experiencing more loneliness than older generations³; and

14
15 Whereas, Loneliness in adolescence is associated with impaired sleep, symptoms of
16 depression, and poorer health in general⁴; and

17
18 Whereas, Loneliness is a significant predictor of functional decline and premature death equal
19 to or exceeding the risk from obesity^{5,6}; and

20
21 Whereas, Increased meaningful daily interactions and multiple sources of social support are
22 associated with decreased loneliness^{3,7}; and

23
24 Whereas, Decades of research provide evidence for the strong causal relationship between
25 social relationships and health and longevity⁸; and

26
27 Whereas, The United Kingdom has recognized loneliness as an epidemic and has appointed a
28 Minister of Loneliness to address loneliness in the UK, directed federal funding towards
29 expanding the Shared Lives program, and encourages physicians to offer “social prescribing” to
30 connect patients with community activities^{9,10}; and

31
32 Whereas, The American Psychological Association, the National Academies of Science,
33 Engineering, and Medicine, Surgeon General Vivek Murthy, and many other health
34 organizations have publicly spoken out about loneliness as a public health problem in the US<sup>11-
35 13</sup>; and

36
37 Whereas, Our AMA has passed policy to publicly recognize the association between senior
38 suicide and loneliness (H-25.992) and the negative effects of solitary confinement on
39 imprisoned juveniles (H-60.922), but no policy exists addressing loneliness as a public health
40 issue affecting people of all ages; therefore be it

1 RESOLVED, That our American Medical Association release a statement identifying loneliness
2 as a public health issue with consequences for physical and mental health (Directive to Take
3 Action;) and be it further

4
5 RESOLVED, That our AMA support evidence-based efforts to combat loneliness. (New HOD
6 Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY:

Senior Suicide H-25.992

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

Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Health Care for Older Patients H-25.999

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

advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.

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

Policy Recommendations in the Field of Aging H-25.998

It is the policy of the AMA that: (1) Older individuals should not be isolated; (2) a health maintenance program is necessary for every individual; (3) more persons interested in working with older people in medical and other professional fields are needed; (4) more adequate nursing home facilities are an urgent health need for some older people in many communities; (5) further development of service and facilities is required; (6) extension of research on both medical and socioeconomic aspects of aging is vital; (7) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and (8) local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people. 2. Our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states.

CMS Rep. A, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CMS Rep. 1, A-18; Appended: BOT Rep. 11, I-21

Increased Liaison, Communication and Educational Efforts with the Elderly H-25.994

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

Res. 133, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14

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. 8, A-16; Reaffirmed: Res. 917, I-16

Financing of Long-Term Services and Supports H-280.945

Our AMA supports: (1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability; (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities; (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy; (6) Medicare Advantage plans offering LTSS in their benefit packages; (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit; (8) a back-end public catastrophic long-term care insurance program; (9) incentivizing states to expand the availability of and access to home and community-based services; and (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. CMS Rep. 05, A-18; Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 4, I-21

A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987

Our AMA, in collaboration with other interested parties, such as the public health community, geriatric specialties, and organizations working to advocate for seniors, will create a repository of available

resources for physicians to guide healthy practices for seniors who reside in independent living communities.

Res. 418, A-18

Senior Care H-25.993

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

Sub Res. 181, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Clinical Preventive Services H-425.984

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

CSA Rep. D, I-92; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 1, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-22)

Introduced by: Medical Student Section

Subject: Support for Democracy

Referred to: Reference Committee D

1 Whereas, Democracy is most commonly defined as a system of government wherein the people
2 exercise power either directly or indirectly through representatives who are periodically chosen
3 in free and fair elections¹⁻⁴; and
4

5 Whereas, A 2019 study published in *The Lancet* found that “when enforced by free and fair
6 elections, democracies are more likely than autocracies to lead to health gains for causes of
7 mortality (e.g., cardiovascular diseases and transport injuries) that have not been heavily
8 targeted by foreign aid and require health-care delivery”⁵; and
9

10 Whereas, Multiple studies have shown a clear positive correlation between electoral integrity in
11 democracies and improvements in indicators of population health, including infant mortality,
12 mortality from cardiovascular disease and other communicable diseases, and tuberculosis⁶⁻⁹;
13 and
14

15 Whereas, A recent study including data from 168 countries from 1960 through 2010 found a
16 positive association between democracy and life expectancy that remained even after
17 controlling for potential confounders like gross domestic product (GDP) per capita¹⁰; and
18

19 Whereas, An analysis of the shift to electronic voting in Brazil, which disproportionately enabled
20 the poor and less well-educated to participate in elections, showed the change led to increases
21 in health spending that increased utilization of prenatal care and decreased the number of
22 children being born at low weight, suggesting that increasing access to meaningful elections can
23 improve population health¹¹; and
24

25 Whereas, A 2018 analysis comparing different Indian states across core attributes of democracy
26 showed that having higher voter turnout and more political parties were both significantly
27 associated with reductions in infant mortality¹²; and
28

29 Whereas, One study showed that the presence of competitive elections in autocracies was
30 associated with better life expectancy and rates of infant mortality as compared to autocracies
31 without competitive elections¹³; and
32

33 Whereas, Studies have shown that democracies may enhance the beneficial effects of various
34 societal transformations, including trade liberalization and foreign aid, on population health¹⁴⁻¹⁷;
35 and
36

37 Whereas, Studies have shown that democracies may suppress the harmful effects of a variety
38 of negative economic indicators and disasters, including storms, floods, droughts, and other
39 environmental disruptions, extreme price volatility, and excessive mining and mineral extraction,
40 on overall population health¹⁸⁻²⁰; and

Whereas, An August 2021 analysis of 170 countries over the time period from 1990 to 2019 published in *Health Affairs* indicated that democratic quality and universal health coverage have a statistically significant positive association, with free and fair elections identified as having the strongest association with higher universal health coverage²¹; and

Whereas, A 2020 *BMJ* study of 17 countries found that decreases in democratic traits, including free and fair elections, freedom of expression, freedom of civil and political association, between 2000 and 2010 were associated with lower life expectancy, reduced progress toward universal health coverage, and increased out-of-pocket spending on healthcare²²; and

Whereas, The annual Freedom House reports, which rate the political and civil rights of countries around the globe, have tracked a steady decline in multiple dimensions of democracy in the United States from 2010 to 2020²³⁻²⁵; and

Whereas, From November 2020 to January 2021, multiple key government officials attempted to subvert the results of the 2020 presidential election through a variety of mechanisms²⁶⁻³⁰; and

Whereas, During the counting of electoral votes on January 6-7, 2021, hundreds of Representatives and Senators in Congress voted to reject electoral votes from key states in an attempt which, if it had been successful, would have overturned the results of the 2020 presidential election³¹⁻³³; and

Whereas, Multiple state legislatures have since passed laws that provide unprecedented control over state and local elections and could permit those legislatures to subvert election results³⁴⁻³⁷; and

Whereas, These antidemocratic trends in the United States directly threaten the ability of physicians and their patients to make their voices heard, thereby depriving them of a key avenue to maximize their health and well-being; therefore be it

RESOLVED, That our American Medical Association unequivocally support the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans (New HOD Policy); and be it further

RESOLVED, That our AMA strongly oppose attempts to subvert the democratic process (Directive to Take Action); and be it further

RESOLVED, That our AMA assert that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

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: CC&B Rep. 2, A-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Endorsements for Public Office G-605.035

Our AMA requires that all of its endorsements of nominations of appointed officials for public office be considered and voted upon by our Board of Trustees prior to any public pronouncements of support.

Rep. of the Task Force on Recording and Reporting of Trustees' Votes, A-11; Reaffirmed: CCB/CLRPD Rep. 3, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-22)

Introduced by: Medical Student Section

Subject: Support for Pediatric Siblings of Chronically Ill Children

Referred to: Reference Committee D

1 Whereas, Nearly 43% of US children are currently living with at least 1 of 20 recognized chronic
2 childhood illnesses including cerebral palsy, cystic fibrosis, and developmental disabilities¹; and
3

4 Whereas, Nearly 1 in 408 children will be diagnosed with cancer before the age of 15, and 1 in
5 285 children are diagnosed with cancer before the age of 20, with rates of diagnoses increasing
6 since 1975²; and
7

8 Whereas, Chronic pediatric illnesses affect the healthy siblings' relationship with their parents
9 and their ill sibling³; and
10

11 Whereas, Siblings of pediatric cancer patients face psychological and emotional challenges
12 associated with chronic illness, including experiencing feelings of loneliness, jealousy, guilt, and
13 anxiety⁴; and
14

15 Whereas, Studies have shown that bereaved patients report difficulty sleeping, reduced self-
16 esteem and maturity for as long as nine years after a sibling's death, alongside experiencing
17 difficulties in school including decreased attendance and performance but may benefit from
18 relationships with their teachers and peers^{4,5}; and
19

20 Whereas, Interventions for well-being have a positive effect on the psychological functioning of
21 siblings of children and young people with a chronic illness⁶; and
22

23 Whereas, Summer camp programs designed specifically for pediatric oncology patients and
24 their siblings to interact and share their experiences have improved campers' reports of
25 perceived social support and self-esteem, as well as improved understanding of their emotions
26 and the emotions of others^{7,8}; and
27

28 Whereas, A study with 2,114 children across 19 summer camps indicated that summer camp
29 programs can be beneficial for pediatric oncology patients and their siblings by improving social,
30 emotional, physical, and self-esteem functioning, regardless of demographic factors and
31 whether camp sessions included patients only, siblings only, or both⁷; and
32

33 Whereas, A study of 56 siblings of pediatric patients with disabilities enrolled in a cognitive-
34 behavioral support group program were shown to have fewer emotional and behavioral
35 problems immediately after the program as well as at a 3-month follow up compared to their
36 peers who were not enrolled in the program⁹; and
37

38 Whereas, AMA policy supports providing resources to the caregivers of patients with chronic
39 illnesses (H-210.980) but does not address the needs of siblings; therefore be it

- 1 RESOLVED, That our American Medical Association support programs and resources that
- 2 improve the mental health, physical health, and social support of pediatric siblings of chronically
- 3 ill pediatric patients. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

H-210.980 Physicians and Family Caregivers: Shared Responsibility

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;

(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers;

and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients. Res. 308, I-98, Reaffirmation: A-02,

Reaffirmed: CME Rep. 2, A-12, Appended: Res. 305, A-17

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);

b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;

c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;

d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and

e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Res. 504, A-19; Appended: CSAPH Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 435
(A-22)

Introduced by: Medical Student Section

Subject: Support Removal of BMI as a Standard Measure in Medicine and
Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

Referred to: Reference Committee D

1 Whereas, Body mass index (BMI) is used across medicine as a screening tool to classify
2 individuals as underweight, healthy weight, overweight, and obese, and is calculated from a
3 person's height and weight; it is a screening tool in healthcare that is frequently utilized as a
4 surrogate estimation of body fat through the measurement of total body weight rather than total
5 body fat^{1,2,3}; and

6
7 Whereas, Underlying assumptions are that BMI directly correlates to levels of body fat
8 (adiposity); however, many factors besides body fat (adiposity) impact BMI, including muscle
9 mass, gender, and race/ethnicity, and such factors limit the ability of BMI to be used to reliably
10 predict general health and disease risk⁴; and

11
12 Whereas, There is minimal evidence supporting the clinical utility of BMI; however, in many
13 clinical settings certain BMI ranges are broadly correlated with increased rates of morbidity and
14 mortality secondary to several different disease processes without consideration of individual
15 and population level differences⁵; and

16
17 Whereas, Numerous medical specialty organizations recognize several measures as a useful
18 adjunct or alternative to BMI that could be used clinically, including waist circumference, relative
19 fat mass, body adiposity index, and the body volume index, all of which have been studied in
20 the literature⁶⁻¹⁵; and

21
22 Whereas, The development of BMI was based solely on those of European descent in an effort
23 to define the characteristics of the "normal man;"¹⁶ and

24
25 Whereas, The development of BMI and its apparent association with specific disease processes
26 were based on primarily white males of European descent and is not a standardized across
27 racial and ethnic groups and has limited predictive validity in these groups^{4,6,17}; and

28
29 Whereas, The association between BMI levels and risks varies among different racial groups;
30 for example, there is a link between BMI and metabolic abnormalities in the white population,
31 but this association is not found among other racial groups¹⁸; and

32
33 Whereas, BMI has been shown to have a low sensitivity for body fat mass and may lead to
34 inadequate prevention of obesity-related health complications, especially in at-risk populations
35 such as women and children^{16,19,20}; and

36
37 Whereas, BMI categorization fails to serve as a predictor for obesity in white, Black or Hispanic
38 women either pre- or post-menopause^{21, 22}; and

1 Whereas, Despite limited evidence for its clinical validity, BMI is used as an indicator of eating
2 disorder presence and severity, which impairs access to treatment and is not predictive of the
3 severity of eating disorder psychology, and in fact may be inversely correlated²³⁻²⁶; and
4

5 Whereas, The DSM-V defines a binge-eating episode as “eating, in a discrete period of time, an
6 amount of food that is definitely larger than most people would eat in a similar period of time
7 under similar circumstances,” and binge eating disorder is the most prevalent eating disorder in
8 the United States with a lifetime prevalence of 2.8%^{27,28}; and
9

10 Whereas, Recent evidence has shown significant differences in the prevalence of binge-eating
11 symptoms in non-Hispanic White populations and non-Hispanic Black populations²⁹; and
12

13 Whereas, Rates of obesity, body satisfaction, and depression vary among ethnic groups,
14 causing heterogeneity in the prevalence of eating disorders within these groups, and some
15 studies suggest that the increased risk of disordered eating in ethnic minority adolescents may
16 result from higher levels of stress due to minority status^{30,31,32}; and
17

18 Whereas, Research has shown that men and ethnic/racial minorities are significantly less likely
19 to seek help for binge eating disorders than women or non-Hispanic White people³³; and
20

21 Whereas, Studies have documented lower rates of treatment for eating disorders among some
22 specific diverse populations due to differences in clinical presentation, differences in help-
23 seeking patterns, and clinician error or bias³⁴⁻³⁶; and
24

25 Whereas, Stigma associated with a health care provider’s assessment of body weight is
26 associated with medication nonadherence, mistrust of the provider, and avoidance of medical
27 care³⁷; and
28

29 Whereas, Inclusive, non-stigmatizing approaches to health promotion must also acknowledge
30 the social and economic determinants of health and take into consideration the patient’s lived
31 environment for physicians to help patients achieve meaningful and sustainable health goals³⁷;
32 and
33

34 Whereas, A recent overview of Cochrane systematic reviews has shown that of all studied
35 psychosocial interventions, the cognitive behavioral approach was most effective for binge-
36 eating disorder, bulimia, nervosa, and night eating syndrome³⁸; and
37

38 Whereas, Research suggests culturally sensitive Cognitive Behavioral Therapy (CBT) is both
39 feasible and efficacious; for example, a qualitative study has shown that culturally adapted CBT-
40 guided self-help has been well received and is a feasible treatment for Mexican American
41 women with binge-eating disorder^{39,40,41}; and
42

43 Whereas, Our AMA has set precedents for supporting additional research on the efficacy of
44 screening for obesity using indicators other than BMI in the pursuit of improving various clinical
45 outcomes across populations (H-440.866) and increased funding for research on the diagnosis
46 of eating disorders (H-150.928); and
47

48 Whereas, In 2013 the AMA Council on Science and Public Health (CSAPH) released a report
49 that recognized the need for better measures of obesity than BMI and rescinded policy
50 D-440.971, “Recommendations for Physician and Community Collaboration on the Management
51 of Obesity” which encouraged physicians to incorporate BMI in the routine adult physical

1 examination; this recommendation demonstrated our AMA's recognition of the lack of evidence
2 supporting the routine clinical use of BMI⁴²; and
3

4 Whereas, Binge-eating is the most prominent presentation of eating disorders, particularly in
5 minority populations, but is not specified in current AMA policy despite less prevalent
6 presentations such as weight restriction being specified; therefore, be it
7

8 RESOLVED, That our American Medical Association recognize the significant limitations and
9 potential harms associated with the widespread use of body mass index (BMI) in clinical
10 settings and supports its use only in a limited screening capacity when used in conjunction with
11 other more valid measures of health and wellness (Directive to Take Action); and be it further
12

13 RESOLVED, That our AMA support the use of validated, easily obtained alternatives to BMI
14 (such as relative fat mass, body adiposity index, and the body volume index) for estimating risk
15 of weight-related disease (New HOD Policy); and be it further
16

17 RESOLVED, That our AMA amend policy H-440.866, "The Clinical Utility of Measuring Body
18 Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight
19 and Obesity," by addition and deletion to read as follows:
20

21 The Clinical Utility of Measuring ~~Body Mass Index~~ Weight, Adiposity, and Waist
22 Circumference in the Diagnosis and Management of Adult Overweight and Obesity,
23 H-440.866

24 Our AMA supports:

25 (1) greater emphasis in physician educational programs on the risk differences ~~among~~
26 ~~ethnic and age within and between demographic groups~~ at varying weights and levels
27 of adiposity BMI and the importance of monitoring waist circumference in all individuals
28 with BMIs below 35 kg/m²;

29 (2) additional research on the efficacy of screening for overweight and obesity, using
30 different indicators, in improving various clinical outcomes across populations, including
31 morbidity, mortality, mental health, and prevention of further weight gain; and

32 (3) more research on the efficacy of screening and interventions by physicians to
33 promote healthy lifestyle behaviors, including healthy diets and regular physical activity,
34 in all of their patients to improve health and minimize disease risks. (Modify Current
35 HOD Policy); and be it further
36

37 RESOLVED, That our AMA amend policy H-150.965, by addition to read as follows in order
38 to support increased recognition of disordered eating behaviors in minority populations and
39 culturally appropriate interventions:
40

41 H-150.965 – EATING DISORDERS

42 The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious
43 to one's physical and mental health as obesity; (2) asks its members to help their
44 patients avoid obsessions with dieting and to develop balanced, individualized
45 approaches to finding the body weight that is best for each of them; (3) encourages
46 training of all school-based physicians, counselors, coaches, trainers, teachers and
47 nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive
48 behaviors in adolescents and to offer education and appropriate referral of adolescents
49 and their families for culturally-informed interventional counseling; and (4) participates
50 in this effort by consulting with appropriate and culturally informed educational and
51 counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight
52 restrictive behaviors. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Eating Disorders H-150.965

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.

Res. 417, A-92, Appended: Res. 503, A-98, Modified and Reaffirmed: CSAPH Rep. 2, A-08, Reaffirmed: CSAPH Rep. 1, A-18

Eating Disorders and Promotion of Healthy Body Image H-150.928

Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

CSAPH Rep. 1, A-17

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res. 412, A-06, Appended: Res. 907, I-12, Reaffirmed in lieu of: Res 001, I-16

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

CMS Rep. 9, A-01, Reaffirmation: A-11, Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12, Reaffirmed in lieu of: Res. 804, I-13, Reaffirmed in lieu of: Res. 808, I-14, Reaffirmed: Res. 503, A-17, Reaffirmation: I-18

H-440.866: The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity

Our AMA supports:

(1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m²;
 (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
 (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13

G-600.064: AMA Endorsement of Screening Tests or Standards

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.

CSA Rep. 7, A-02CC&B Rep. 3, I-08Reaffirmed: CCB/CLRPD Rep. 3, A-12

H-170.995 Healthful Lifestyles

The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.

BOT Rep. A, NCCMC Rec. 48, A-78Reaffirmed: CLRPD Rep. C, A-89Res. 402, I-94Reaffirmed: CSA Rep. 6, A-04, Reaffirmed: BOT Rep. 8, I-06Reaffirmed: CSAPH Rep. 01, A-16

H-150.965: Eating Disorders

The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting and weight restrictive behaviors in

adolescents and to offer education and appropriate referral of adolescents and their families for culturally informed interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.

Res. 417, A-92Appended by Res. 503, A-98Modified and Reaffirmed: CSAPH Rep. 2, A-08Reaffirmed: CSAPH Rep. 01, A-18

H-150.928: Eating Disorders and Promotion of Healthy Body Image

Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

CSAPH Rep. 01, A-17

H-150.953: Obesity as a Major Public Health Problem

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

CSA Rep. 6, A-99; Reaffirmation A-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

H-440.902: Obesity as a Major Health Concern

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

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

D-440.954: Addressing Obesity

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.

BOT Rep. 11, I-06Reaffirmation A-13Appended: Sub. Res. 111, A-14Modified: Sub. Res. 811, I-14Appended: Res. 201, A-18

H-320.953: Definitions of "Screening" and "Medical Necessity"

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

CMS Rep. 13, I-98Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99Modified: Res. 703, A-03Reaffirmation I-06, Reaffirmed: CMS Rep. 01, A-16

D-440.980: Recognizing and Taking Action in Response to the Obesity Crisis

Our AMA will: (1) advocate for the creation of a multidisciplinary federal task force, including representation from the medical profession, to review the public health impact of obesity and recommend measures to: (a) better recognize and treat obesity as a chronic disease; and (b) confront the epidemic of obesity and its root causes, particularly among populations with disproportionately high incidence; (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.

Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified - BOT Action in response to referred for decision: Res. 403, A-21

H-440.842: Recognition of Obesity as a Disease

Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Res. 420, A-13

H-425.994: Medical Evaluations of Healthy Persons

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CMS Rep. 03, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 436
(A-22)

Introduced by: Medical Student Section

Subject: Training and Reimbursement for Firearm Safety Counseling

Referred to: Reference Committee D

1 Whereas, Firearm ownership is embedded within United States (US) culture with nearly 22% of
2 individuals owning a firearm and 35% living in a household with firearms¹; and
3

4 Whereas, The incidence of firearm-related mortality in the U.S. has increased in a 15-year period,
5 from 10.3 deaths per 100,000 in 2007 to 13.7 deaths per 100,000 in 2020²; and
6

7 Whereas, Firearm-related hospitalizations (FRHs) contribute to substantial physical morbidity,
8 psychological and societal costs, and higher risk of subsequent violent victimization and crime
9 perpetration³; and
10

11 Whereas, Firearm injuries create a disproportionate burden of morbidity and mortality on people
12 of color, highlighting racial disparities in firearm access and health outcomes⁷⁻¹¹; and
13

14 Whereas, Over 4 billion dollars were spent on firearm injuries in emergency departments from
15 2006-2016, demonstrating the significant and increasing economic burden of gun violence in the
16 US¹²⁻¹⁵; and
17

18 Whereas, Physician-led firearm counseling was ruled protected under First Amendment rights by
19 *Wollschlaeger v. Governor, State of Florida*, which invalidated Florida's Firearm Owners' Privacy
20 Act that prevented physicians from asking patients about firearm ownership¹⁶; and
21

22 Whereas, Although organizations including the AMA and American Academy of Pediatrics
23 (AAP) agree that physicians should counsel patients on firearm safety, only 25% of family
24 physicians, psychiatrists, and internists provide this counseling very often or often¹⁷⁻¹⁸; and
25

26 Whereas, One study reported that only 15% of physicians documented firearm counseling
27 discussions with patients, naming factors including lack of physician training, time constraints,
28 and fear of offending patients and families¹⁹⁻²²; and
29

30 Whereas, A study of pediatrics resident physicians demonstrated that after a workshop about
31 firearm safety counseling, residents were 5 times more likely to counsel their patients on
32 firearms and had greater comfort during the discussion, due to increased knowledge on
33 recommendations and safe storage²²; and
34

35 Whereas, Physician firearm counseling, when combined with firearm safety devices, has
36 demonstrated improvements in firearm storage in patients' homes from increased availability of
37 locks and safes and increased patient education²³; and

1 Whereas, The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) has
2 convened a working group to develop curricula to help educate future physicians about firearms
3 safety²⁴; and
4

5 Whereas, Numerous medical schools, including Donald and Barbara Zucker School of Medicine
6 at Hofstra/Northwell, Icahn School of Medicine at Mount Sinai, McGovern Medical School, Miller
7 School of Medicine, and Washington University School of Medicine in St. Louis have already
8 incorporated firearm-related injury prevention education into their curriculum²⁵; and
9

10 Whereas, Individuals at greater risk for firearm injury include those involved in intimate-partner
11 violence and community violence, or those with mental illness, suicidal ideation, and cognitive
12 decline²⁶⁻²⁸; and
13

14 Whereas, Efficient use of physician time and resources can be encouraged through
15 implementation of screening of individuals who are at higher risk for firearm injury²⁹⁻³¹; and
16

17 Whereas, Examples of reimbursement for other preventive education have demonstrated that
18 increased counseling by physicians and improved patient health outcomes; for example,
19 preventive smoking cessation counseling increased cessation rates by 30%, and since the
20 Affordable Care Act included smoking cessation counseling coverage in 2014, more people
21 have quit smoking³²⁻³³; and
22

23 Whereas, Smoking cessation counseling, which is reimbursed independently by insurance
24 companies, can prevent over 50,000 smoking-attributable fatalities and reduce smoking
25 prevalence by 5.5 percentage points, and firearm counseling would be expected to follow this
26 same trend³⁴; and
27

28 Whereas, Medicaid and Medicare value-based reimbursement of preventative services has
29 been shown to improve health outcomes through rewarding quality care from primary care
30 physicians³⁵; and
31

32 Whereas, Physician decision-making has been linked to financial incentives, suggesting that
33 value-based payments specifically for firearm safety counseling may drive increased rates of
34 counseling and improved health outcomes, similar to other preventive care reimbursement
35 strategies³⁶; and
36

37 Whereas, Although the 2021 ICD-10-CM diagnosis code Z71.89 encompasses other specified
38 counseling, this does not cover specific topics such as firearm storage and prevention of
39 firearm-related injuries³⁷; and
40

41 Whereas, Other preventive counseling efforts, including smoking cessation, alcohol misuse,
42 dental health, diet, and sexually transmitted diseases, have their own designated ICD-10
43 codes³⁷⁻³⁸; and
44

45 Whereas, For the high-risk subpopulation of older adults, firearm counseling could be
46 incorporated into a patient's Medicare Annual Wellness Visit (AWV) to be billed under the
47 preventive services modifier and to provide remuneration for physicians providing counseling³⁹;
48 and
49

50 Whereas, AMA Policies H-145.990, H-145.975, and H-145.976 address the need for firearm
51 injury prevention, safe firearm storage, and improved physician counseling and dissemination of

educational materials, but do not address inclusion in medical curricula or specify how physicians should be reimbursed for such efforts; and

Whereas, Physicians should be incentivized to provide firearm safety counseling for patients through a combination of education and appropriate compensation for their time and efforts, contributing to reduced morbidity and mortality from firearms; therefore be it

RESOLVED, That our American Medical Association support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-145.976, "Firearm Safety Counseling in Physician-Led Health Care Teams," by addition to read as follows:

Firearm Safety Counseling in Physician-Led Health Care Teams, H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY:

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to

facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

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, Reaffirmed: CSAPH Rep. 3, A-21

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. Res. 425, I-98, Reaffirmed: Res. 409, A-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmation: A-13

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Res. 204, I-98, Reaffirmed: BOT Rep. 23, A-09, Reaffirmed: CSAPH Rep. 1, A-19

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Res. 219, I-11, Reaffirmation: A-13, Modified: Res. 203, I-13, Appended: Res. 419, A-17, Reaffirmed: CSAPH Rep. 4, A-18, Reaffirmed: CSAPH Rep. 3, I-21

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

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. 4, A-18, Reaffirmation, A-18, Reaffirmation, I-18, Appended: Res. 405, A-19

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Res. 410, A-13

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Res. 410, A-93, Reaffirmed: CLRPD Rep. 5, A-03, Reaffirmation: A-13, Modified: CSAPH Rep. 1, A-13

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation: A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

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.

BOT Rep. 11, A-18; Reaffirmed: CSAPH Rep. 3, I-21

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

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation: A-13

Strategies to Address Rising Health Care Costs H-155.960

Our AMA:

- (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
- (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
- (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
- (d) promote "value-based decision-making" at all levels;
- (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;

- (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
 - (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
 - (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
 - (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
 - (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
 - (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
- CMS Rep. 8, A-07; Reaffirmed; CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation: A-09; Reaffirmation: I-09; Reaffirmation: A-11; Reaffirmation: I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed; CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation: I-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CME CSAPH Rep. 01, I-18

Stark Law and Physician Compensation H-385.914

Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.
BOT Rep. 6, I-15

Physicians and Family Caregivers: Shared Responsibility H-210.980

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.

Res. 308, I-98; Reaffirmation: A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.
Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

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

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

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

administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

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

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

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

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

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

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

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

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

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

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. CME Rep. 04, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-22)

Introduced by: Undersea and Hyperbaric Medical Society

Subject: Oppose “Mild Hyperbaric” Facilities from Delivering Unsupported Clinical Treatments

Referred to: Reference Committee E

1 Whereas, So called “mild hyperbaric facilities” have become numerous in the very recent past
2 consisting of at least 288 locations in 31 states in the United States; and
3

4 Whereas, These centers are treating and charging clients mostly for scientifically unsupported
5 disease entities and conditions without any or with inadequate evidence and without intention to
6 analyze results and add to the compendium of medical knowledge; and
7

8 Whereas, These centers take advantage of vulnerable populations including those suffering
9 from autism, multiple sclerosis, cerebral palsy, and post-stroke injuries; and
10

11 Whereas, These centers offer clients improvement in general health and wellness without any
12 substantiating science or even reasonably predicated mechanisms; and
13

14 Whereas, When “mild hyperbaric” centers do treat conditions in which published experience and
15 scientific evidence support the use of hyperbaric oxygen, they fail to use time-tested protocols.
16 Typically, their treatments deliver pressures just over 1.0 ATA (atmospheres absolute) and less
17 than 1.4 ATA. They also fail to deliver inhaled oxygen concentrations near 100% oxygen to the
18 patient. Both of these fall very short of time-tested treatment parameters; and
19

20 Whereas, Treatments are offered without physician oversight or prescription, and without
21 appropriately trained staff; and
22

23 Whereas, Treatments are delivered often in unsafe environments with inadequately trained staff
24 and without required safety and fire suppression equipment in chambers that are not FDA-
25 certified and for which no 510K application has been made; therefore be it
26

27 RESOLVED, That our American Medical Association oppose the operation of “mild hyperbaric
28 facilities” unless and until effective treatments can be delivered in safe facilities with
29 appropriately trained staff including physician supervision and prescription and only when the
30 intervention has scientific support or rationale. (New HOD Policy)

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

Received: 05/08/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-22)

Introduced by: Undersea and Hyperbaric Medical Society

Subject: Safeguard the Public from Widespread Unsafe Use of “Mild Hyperbaric Oxygen Therapy”

Referred to: Reference Committee E

1 Whereas, There has been a recent proliferation of “mild hyperbaric” activities outside medical
2 facilities in chiropractic centers, wellness centers and health spas. The magnitude of these
3 practices is documented to be widespread, occurring in at least 288 centers in 31 states; and
4

5 Whereas Pressure vessels (chambers) employed by these centers are not typically inspected,
6 certified, or approved by the appropriate standards and regulatory agencies including the FDA
7 and ASME (American Society of Mechanical Engineers). Many chambers are being imported
8 from foreign countries. At least two U.S. companies are also involved in design, manufacture,
9 and sales of inadequately designed chambers. In both cases, the manufacturers do not seek
10 the required certification of pressure vessels for human occupancy inappropriately marketing
11 these as medical hyperbaric chambers with no valid FDA 510K clearance; and
12

13 Whereas, These treatments are being conducted without physician supervision or prescription.
14 In the event of chamber integrity failure, patients are subject to serious injury and even death by
15 barotrauma. Furthermore, additional complications including hypoglycemic reactions and
16 unrecognized cardiac emergencies can occur and require immediate physician recognition and
17 intervention; and
18

19 Whereas, Without regard to the inherent risk of fire in this special environment, most of these
20 facilities operate with chambers installed into business spaces not adherent to the safety
21 regulations of the NFPA (National Fire Protection Association) and not protected by sprinkler
22 systems, alarms or other safety equipment; and
23

24 Whereas The staff delivering the actual hyperbaric exposures in “mild hyperbaric facilities” are
25 not receiving comprehensive training in chamber operation, safety and emergency prevention;
26 and
27

28 Whereas, Heath Canada has already banned future sales of soft sided mild hyperbaric
29 chambers often used in “mild hyperbaric” applications and called for the recall of those already
30 sold; and
31

32 Whereas, These centers often promote and advertise false and misleading applications in the
33 treatment in non-compliance with FDA regulations; therefore be it
34

35 RESOLVED, That our American Medical Association oppose the operation of unsafe “Mild
36 Hyperbaric Facilities” (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA work with the U.S. Food and Drug Administration and other
- 2 regulatory bodies to close these facilities until and unless they adopt and adhere to all
- 3 established safety regulations, adhere to the established principles of the practice of hyperbaric
- 4 oxygen under the prescription and oversight of a licensed and trained physician, and ensure
- 5 that staff are appropriately trained and adherent to applicable safety regulations. (Directive to
- 6 Take Action)

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

Received: 05/08/22

References:

1. American Society of Mechanical Engineers (ASME) PVHO-1–2012 (Pressure Vessels for Human Occupancy) Revision of ASME PVHO-1–2007)
2. Government of Canada. "Unauthorized soft-shelled hyperbaric chambers may pose serious health risks." Canada.ca, Government of Canada, Oct. 2019, [recalls-rappels.canada.ca/en/alert-recall/ unauthorized-soft-shelled-hyperbaric-chambers-may-pose-serious-health-risks](https://recalls-rappels.canada.ca/en/alert-recall/unauthorized-soft-shelled-hyperbaric-chambers-may-pose-serious-health-risks).
3. National Fire Protection Association (NFPA) Part 99: Health Care Facilities Code 2021 Edition

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 518
(A-22)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Over-the-Counter Access to Oral Contraceptives

Referred to: Reference Committee E

1 Whereas, The benefits of contraception, named as one of the 10 great public health
2 achievements of the 20th century by the Centers for Disease Control and Prevention, are widely
3 recognized and include improved health and well-being, reduced global maternal mortality,
4 health benefits of pregnancy spacing for maternal and child health, female engagement in the
5 work force, and economic self-sufficiency;¹ and
6

7 Whereas, Contraception can be lifesaving for people with serious medical conditions like heart
8 disease, cancer or diabetes for whom an unplanned pregnancy can worsen preexisting health
9 conditions; and
10

11 Whereas, Oral contraceptives can have important non-contraceptive benefits, including
12 decreasing risk of endometrial and ovarian cancer, treating heavy menstrual bleeding and
13 dysmenorrhea, and reducing pelvic pain due to endometriosis;² and
14

15 Whereas, Barriers to access are one reason for inconsistent or nonuse of contraception and
16 the requirement for a prescription can be an obstacle for some contraceptive users; and
17

18 Whereas, A national survey of 1,385 women reported that among the 68% of individuals who
19 had ever tried to obtain a prescription for hormonal contraception, 29% had problems
20 accessing the initial prescription or refills, reporting obstacles including challenges in obtaining
21 an appointment or getting to a clinic, the health care provider requiring a clinic visit,
22 examination, or Pap test, and not having a regular physician or clinic;³ and
23

24 Whereas, Surveys repeatedly have demonstrated interest among adolescents and adult
25 women in over-the-counter access to oral contraceptives,^{4,6} including a 2011 national survey
26 about views on over-the-counter oral contraceptives,⁷ a nationally representative, cross-
27 sectional online survey of approximately 2,500 females (aged 15–44 years),⁸ and focus group
28 data from adolescent females and adult women;⁹⁻¹⁰ and
29

30 Whereas, Progestin-only emergency contraception (EC) is already available without a
31 prescription for people of all ages in the United States; and
32

33 Whereas, Pelvic and breast examinations, cervical cancer screening, and sexually transmitted
34 infection screening are not required before initiating hormonal contraception;¹¹⁻¹⁴ and
35

36 Whereas, Studies have shown that women can accurately use checklists to determine if they
37 have contraindications to hormonal contraception; in one study, 96% of cases evaluated
38 demonstrated agreement between a women's assessment of her contraindications using a
39 checklist and a clinician's independent evaluation, and women often take a more conservative
40 approach compared with clinicians;¹⁵⁻¹⁶ and

Whereas, Data support that progestin-only hormonal methods are generally safe and carry no or minimal risk of venous thromboembolism (VTE);¹⁷ and

Whereas, The VTE risk with combined oral contraceptive use is small compared with the increased risk of VTE during pregnancy and the postpartum period;¹⁸ and

Whereas, Oral contraceptive pills are safe and effective for adolescent users, there is no scientific rationale for limiting access to a future over-the-counter oral contraceptive product by age, and over-the-counter access to hormonal contraception has the potential to reduce barriers and increase hormonal contraceptive use for adolescents;¹⁹ and

Whereas, An Oral Contraceptives Over-the-Counter Working Group was formed in 2004 with the aims “to improve access to contraception and reduce disparities in reproductive health outcomes by making a low-cost oral contraceptive product available OTC in the United States;” and

Whereas, Over 100 organizations have signed onto the Oral Contraceptives Over-the-Counter Working Group’s statement of purpose, including the American Academy of Pediatrics, ACOG, the National Hispanic Medical Association, the North American Society for Pediatric and Adolescent Gynecology, and the Society for Adolescent Health and Medicine;²⁰ and

Whereas, Policy statements from the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and American Public Health Association (APHA) support OTC oral contraceptive access;²¹⁻²³ and

Whereas, In December 2016, Ibis Reproductive Health announced a partnership with HRA Pharma to conduct the research needed and submit an application to the FDA to bring a progestin-only oral contraceptive pill to the United States OTC market;²⁴ and

Whereas, Current AMA Policy directs our AMA to encourage manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products; and

Whereas, HRA Pharma completed its final testing phase in 2021 on a progestin-only oral contraceptive and is expected to file a formal application for over-the-counter approval with the U.S. Food and Drug Administration before the end of 2022;²⁵ therefore be it

RESOLVED, That our American Medical Association amend policy D-75.995, “Over-the-Counter Access to Oral Contraceptives,” by addition and deletion to read as follows:

Our AMA:

1. Encourages ~~manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a~~ to swiftly review and approve a switch in status from prescription to over-the-counter for ~~such products~~ oral contraceptives, without age restriction.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.
3. Will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Over-the-Counter Access to Oral Contraceptives D-75.995

Our AMA:

1. Encourages manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

Citation: Sub. Res. 507, A-13; Modified: BOT Rep. 10, A-18

Development and Approval of New Contraceptives H-75.990

Our AMA: (1) supports 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; Modified: CSAPH Rep. 1, A-21

Opposition to HHS Regulations on Contraceptive Services for Minors H-75.998

(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible.

Citation: (Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: Res. 825, I-04; Reaffirmed: CMS Rep. 1, A-14)

Coverage of Contraceptives by Insurance H-180.958

1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.

Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17; Modified: BOT Rep. 10, A-18

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

Access to Emergency Contraception D-75.997

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).
2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

Citation: CMS Rep. 1, A-00; Appended: Res. 506, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 519
(A-22)

Introduced by: Association for Clinical Oncology

Subject: Advanced Research Projects Agency for Health (ARPA-H)

Referred to: Reference Committee E

1 Whereas, The current biomedical and cancer research enterprise has led to the discovery of
2 innovative new treatments for all areas of healthcare through basic and translational research
3 and clinical trials; and
4

5 Whereas, COVID-19 has disrupted biomedical and cancer research and continues to threaten
6 research progress; and
7

8 Whereas, President Biden has called for a major investment in cutting edge/innovative federal
9 research with the establishment of the Advanced Research Projects Agency for Health
10 (ARPA-H); and
11

12 Whereas, Efforts to establish ARPA-H should ensure sustained and dedicated funding to
13 achieve impactful translational research; and
14

15 Whereas, Any reform to the biomedical research enterprise and health innovation efforts should
16 not impact the current or future resources of existing research enterprises; therefore be it
17

18 RESOLVED, That our American Medical Association urge Congress and the Administration to
19 ensure that while providing adequate funding for the promising research conducted at Advanced
20 Research Projects Agency for Health (ARPA-H), it also provides robust annual baseline
21 increases in appropriations for other research agencies, centers, and institutes, including, but
22 not limited to, the NIH and NCI. (Directive to Take Action)

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

Received: 05/11/22

RELEVANT AMA POLICY

Importance of Clinical Research H-460.930

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA encourages and supports development of community and practice-based clinical research networks.

Citation: CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-22)

Introduced by: Medical Student Section

Subject: Addressing Informal Milk Sharing

Referred to: Reference Committee E

1 Whereas, A growing body of evidence supported by the American Academy of Pediatrics (AAP)
2 indicates that breast milk protects growing infants--especially preterm infants--against a variety
3 of dangerous diseases and conditions, including bacteremia, urinary tract infections, lower
4 respiratory tract infections, necrotizing enterocolitis, and sudden infant death syndrome, among
5 others^{1,2}; and
6

7 Whereas, Human milk sharing, also known as using donor human milk, provides access to
8 breast milk for mothers who cannot provide enough for their infants, especially preterm infants
9 in the Neonatal Intensive Care Unit (NICU)³; and
10

11 Whereas, Donor human milk provides nutrients comparable to a mother's own milk, yielding
12 positive effects on neurodevelopment and tolerance of feedings, as well as reduced risk of
13 sepsis and necrotizing enterocolitis, reduced length of stay in the NICU, and direct cost savings
14 ^{4, 5}; and
15

16 Whereas, Informal or peer milk sharing, defined as the practice of donating or receiving donor
17 human milk directly peer-to-peer, is growing in popularity, with tens of thousands of informal
18 milk exchanges occurring via Facebook groups each year and national surveys of milk sharing
19 participants finding that as many as 64% of respondents have obtained donor breast milk
20 informally⁶⁻¹¹; and
21

22 Whereas, Informal milk sharing is associated with many quality concerns, such as dilution with
23 non-human milk which infants are unable to properly digest for the first year of life^{3, 12, 13}; and
24

25 Whereas, Informal milk sharing also carries many safety risks including contamination via
26 infectious or toxic environmental agents, with several studies finding that a significant number
27 of informally shared human milk samples were colonized with disease-causing pathogens,
28 including aerobic bacteria, gram-negative bacteria, and coliform bacteria^{14, 15, 16, 17}; and
29

30 Whereas, These safety risks are of special concern with the coronavirus disease 2019 (COVID-
31 19) pandemic as it cannot be confirmed whether safety precautions known to protect against
32 severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission—including
33 wearing a mask while expressing milk, washing hands and equipment thoroughly, and
34 pasteurizing donor milk—have been taken with informally shared milk^{18, 19}; and
35

36 Whereas, Non-profit milk banks, which are regulated by the Human Milk Banking Association of
37 North America (HMBANA), serve as a safe alternative to informal milk sharing by providing
38 breast milk that is screened, pooled, tested, and pasteurized to be provided to infants in need²⁰;
39 and

Whereas, Non-profit milk banks are associated with many limitations in accessibility, including limited distribution as only 25 non-profit milk banks operate in the United States due to limitations in donor supply and access to funding^{3, 21, 22, 23}; and

Whereas, Already-limited milk supplies at non-profit milk banks are being further strained during the COVID-19 pandemic due to inadequate staffing, challenges with donor recruitment, and safety concerns about donor milk²⁴; and

Whereas, Access to non-profit milk bank breast milk is also limited by cost, as this milk generally costs \$3-\$5 per ounce, and although Medicaid, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other aid-providing programs can help to cover costs, this coverage varies by state^{25, 26}; and

Whereas, The majority of the public is unable to access non-profit milk bank breast milk as a prescription is often required to receive this milk and the majority of non-profit milk bank breast milk is provided to NICUs due to limitations in supply^{3, 27}; and

Whereas, Concerns have risen about informal milk sharing outcompeting milk banks for receipt of human milk donations, and studies have found that women who participate in milk sharing are much more likely to have donated informally than to have donated to a milk bank^{5-10, 28, 29}; and

Whereas, The AAP, the U.S. Food and Drug Administration, the European Milk Bank Association, HMBANA, and the Academy of Breastfeeding Medicine have released statements within the last 5 years discouraging informal milk sharing in favor of milk banking^{3, 8, 9, 27, 30, 31}; and

Whereas, The AMA has existing policy supporting breastfeeding (H-245.982) and breast milk banking (H-245.972) but these policies and the policy statements they support make no mention of informal milk sharing or donation to milk banks; therefore be it

RESOLVED, That our American Medical Association discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization (New HOD Policy); and be it further

RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means (Directive to Take Action); and be it further

RESOLVED, That our AMA support further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Breast Milk Banking H-245.972

Our AMA encourages breast milk banking.

Res. 443, A-07; Reaffirmed: CSAPH Rep. 01, A-17

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to

implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409; A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 521
(A-22)

Introduced by: Medical Student Section

Subject: Encouraging Brain and Other Tissue Donation for Research and Educational Purposes

Referred to: Reference Committee E

1 Whereas, Postmortem tissue contains invaluable information that can be used for medical
2 research and educational purposes to improve our understanding of human physiology and
3 pathophysiology and thus enhance patient care¹; and
4

5 Whereas, Recent research using postmortem brain tissue has been critical to our understanding
6 of the pathogenesis of neurological and psychiatric illnesses such as Parkinson's disease,
7 dementia, PTSD, autism, and major depression, and builds upon advances from neuroimaging,
8 genetic, biomarker, and animal studies²⁻⁸; and
9

10 Whereas, States have taken efforts to raise awareness of and increase donation for organ
11 transplant, such as by asking individuals if they would like to join transplant donor registries
12 when they apply for or renew their driver's licenses^{9,10}; and
13

14 Whereas, In Texas alone, nearly 7 million people have joined the Texas Donor Registry since a
15 question regarding organ donation for transplantation was added to driver's license
16 applications¹¹; and
17

18 Whereas, Ninety-eight percent of organ donation registration occurs at the Bureau of Motor
19 Vehicles, and promotional materials and clerk educational training has been shown to increase
20 organ donation registration by up to 7.8%^{10,12}; and
21

22 Whereas, Although some states offer an option for organ donation and/or tissue donation for
23 research purposes via donor cards, brain tissue donation requires a separate consenting
24 process that often occurs after death through the next of kin^{13,14}; and
25

26 Whereas, Willed body program recruitment is not standardized across institutions and can
27 create a large financial and logistic burden on institutions¹; and
28

29 Whereas, Widespread efforts to inform individuals of the importance of tissue donation for
30 research and health professions education and allow interested individuals the opportunity to
31 easily provide informed consent to donate their bodies for research or education purposes could
32 increase donation rates, decrease costs, and eliminate the need for families to make decisions
33 for their loved ones postmortem¹⁵; and
34

35 Whereas, These efforts could include strategies used to increase organ donation for
36 transplantation, such as asking individuals if they would like to donate other tissue for research
37 purposes when applying for or renewing a driver's license¹⁰; and

Whereas, A study of public perceptions surrounding whole-body donation found that 58.8% of participants reported insufficient understanding of the body and tissue donation process for research and educational purposes, 77.4% reported that they did not know how to register to become a whole-body donor, and 23.9% reported that they did not know they could be registered as both a transplant organ donor and whole-body donor or tissue donor¹⁶; and

Whereas, Several studies have found that after receiving information about the tissue donation process, the majority of participants would be likely or somewhat likely to donate their brain tissue (>60%) for research¹⁷⁻¹⁹; and

Whereas, While current AMA policies H-370.984, H-370.995, H-370.996, and H-370.998 address increasing public education and donation rates for transplantation, they do not address postmortem tissue donation for primarily scientific or educational purposes; therefore be it

RESOLVED, That our American Medical Association support the production and distribution of educational materials regarding the importance of postmortem tissue donation for the purposes of medical research and education (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the inclusion of additional information and consent options for brain and other tissue donation for research purposes on appropriate donor documents (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all persons to consider consenting to tissue donation including brain tissue for research purposes (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage efforts to facilitate recovery of postmortem tissue including brain tissue for research and education purposes. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Importance of Clinical Research H-460.930

- (1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
- (2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
- (3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
- (4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
- (5) Our AMA encourages and supports the development of community and practice-based clinical research networks. CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation: A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 1, A-18

Physician Involvement in Research: Opinion E-7.1.1

Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.

However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.

Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) and individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.

Physicians who are involved in research with human participants have an ethical obligation to ensure that participants' interests are protected and to safeguard participants' welfare, safety, and comfort.

To fulfill these obligations, individually, physicians who are involved in research should:

- (a) Participate only in those studies for which they have relevant expertise.
- (b) Ensure that voluntary consent has been obtained from each participant or from the participant's legally authorized representative if the participant lacks the capacity to consent, in keeping with ethics guidance. This requires that:
 - (i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;
 - (ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;
 - (iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.
- (c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.
- (d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.
- (e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
- (f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating the results of the research.

AMA Principles of Medical Ethics: I, II, III, V Issued: 2016

Organ Donation D-370.985

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

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

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99, Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep.1, A-12

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

CEJA Rep. K, A-93, Reaffirmed: CSA Rep. 12, I-99, Reaffirmed: CSA Rep. 6, A-00, Appended: Res. 512, A-02, Reaffirmed: CEJA Rep. 3, A-12

Tissue and Organ Donation H-370.983

Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. (Res. 533, A-92 Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.995

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors;(2) the success rate for organ transplantation;(3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and(6) the ethical considerations of organ donor recruitment.

Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)

Organ Donor Recruitment H-370.996

Our AMA (1) continues to urge Americans to sign donor cards; (2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular; (3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card; and (4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation. CSA Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Appended: Res. 509, I-98; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: Res. 006, A-18

Importance of Autopsies H-85.954

1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.
2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.
3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.
4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.
5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.
6. Our AMA calls upon all third-party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third-party payers for autopsies.
7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.
8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.

CCB/CLRPD Rep. 3, A-14

Endorsement of the Uniform Anatomical Gift Act (2006) H-370.968

Our AMA endorses the Uniform Anatomical Gift Act of 2006 and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA. BOT Action in response to referred for decision, Res. 901, I-06; Reaffirmed: BOT Rep. 06, A-16

Organ Donation Education H-370.984

"Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes."

Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep.1, A-12; Modified: Res. 3, A-13

Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.
Res. 012, A-19

Organ Donation After Cardiac Death Code of Medical E-6.1.2

Increasing the supply of organs available for transplant serves the interests of patients and the public and is in keeping with physicians' ethical obligation to contribute to the health of the public and to support access to medical care. Physicians should support innovative approaches to increasing the supply of organs for transplantation while balancing this obligation with their duty to protect the interests of their individual patients.

Organ donation after cardiac death is one approach being undertaken to make greater numbers of transplantable organs available. In what is known as "controlled" donation after cardiac death, a patient who has decided to forgo life-sustaining treatment (or the patient's authorized surrogate when the patient lacks decision-making capacity) may be offered the opportunity to discontinue life support under conditions that would permit the patient to become an organ donor by allowing organs to be removed promptly after death is pronounced. Organ retrieval under this protocol thus differs from usual procedures for cadaveric donation when the patient has died as a result of catastrophic illness or injury.

Donation after cardiac death raises a number of special ethical concerns, including how and when death is declared, potential conflicts of interest for physicians in managing the withdrawal of life support for a patient whose organs are to be retrieved for transplantation, and the use of a surrogate decision maker.

In light of these concerns, physicians who participate in retrieving organs under a protocol of donation after cardiac death should observe the following safeguards:

- (a) Promote the development of and adhere to clinical criteria for identifying prospective donors whose organs are reasonably likely to be suitable for transplantation.
- (b) Promote the development of and adhere to clear and specific institutional policies governing donation after cardiac death.
- (c) Avoid actual or perceived conflicts of interest by:
 - (i) ensuring that the health care professionals who provide care at the end of life are distinct from those who will participate in retrieving organs for transplant;
 - (ii) ensuring that no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death
- (d) Ensure that the decision to withdraw life-sustaining treatment is made prior to and independent of any offer of opportunity to donate organs (unless organ donation is spontaneously broached by the patient or surrogate).
- (e) Obtain informed consent for organ donation from the patient (or surrogate), including consent specifically to the use of interventions intended not to benefit the patient but to preserve organs in order to improve the opportunity for successful transplantation.
- (f) Ensure that relevant standards for good clinical practice and palliative care are followed when implementing the decision to withdraw a life-sustaining intervention.

[AMA Principles of Medical Ethics: I, III, V](#) Issued: 2016

Studying Financial Incentives for Cadaveric Organ Donation E-6.1.3

Physicians' ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence.

Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

- (a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.
- (b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.
- (c) Has been developed in consultation with the population among whom it is to be carried out.
- (d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.
- (e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

[AMA Principles of Medical Ethics: I, III, V, VII, VIII, IX](#), Issued: 2016

Presumed Consent & Mandated Choice for Organs from Deceased Donors E-6.1.4

Organ transplantation offers hope for patients suffering end-stage organ failure. However, the supply of organs for transplantation is inadequate to meet the clinical need. Proposals to increase donation have included studying possible financial incentives for donation and changing the approach to consent for cadaveric donation through "presumed consent" and "mandated choice."

Both presumed consent and mandated choice models contrast with the prevailing traditional model of voluntary consent to donation, in which prospective donors indicate their preferences, but the models raise distinct ethical concerns. Under presumed consent, deceased individuals are presumed to be organ donors unless they have indicated their refusal to donate. Donations under presumed consent would be ethically appropriate only if it could be determined that individuals were aware of the presumption that they were willing to donate organs and if effective and easily accessible mechanisms for documenting and honoring refusals to donate had been established. Physicians could proceed with organ procurement based on presumed consent only after verifying that there was no documented prior refusal and that the family was not aware of any objection to donation by the deceased.

Under mandated choice, individuals are required to express their preferences regarding donation at the time they execute a state-regulated task. Donations under mandated choice would be ethically appropriate only if an individual's choice was made on the basis of a meaningful exchange of information about organ donation in keeping with the principles of informed consent. Physicians could proceed with organ procurement based on mandated choice only after verifying that the individual's consent to donate was documented.

These models merit further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh the ethical concerns.

Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

- (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
- (b) Has been developed in consultation with the population among whom it is to be carried out.

(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.

Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

[AMA Principles of Medical Ethics: I,III,V](#), Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 522
(A-22)

Introduced by: Medical Student Section

Subject: Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido

Referred to: Reference Committee E

Whereas, The most recent epidemiological research shows that approximately 40% of women in the United States have sexual concerns, with 12% reporting distressing sexual problems¹; and

Whereas, It is estimated that 1.2 billion women worldwide will be menopausal or postmenopausal by the year 2030²; and

Whereas, Sexual dysfunction in women can manifest in a number of ways, such as impaired arousal, inability to achieve orgasm, pain with sexual activity, or Hypoactive Sexual Desire Disorder (HSDD), which is defined as a deficiency or absence of sexual fantasies and desire for sexual activity that may cause personal distress or interpersonal difficulty^{1,3}; and

Whereas, Decreased libido in women is currently evaluated and treated using the biopsychosocial model to account for biological, psychological, interpersonal, and sociocultural factors, yet some women may have decreased libido that is refractory to standard treatments^{1,4}; and

Whereas, Testosterone plays a key role in maintaining libido in women, as evidenced by numerous studies that show testosterone significantly improves various aspects of libido in androgen-deficient, premenopausal, naturally post-menopausal, and surgically post-menopausal women, and testosterone levels in postmenopausal women are 50% lower compared to premenopausal women⁵⁻¹⁰; and

Whereas, A large meta-analysis, comprised of 43 articles, 36 randomized controlled trials, and 8,480 naturally or surgically post-menopausal women monitored for at least 12 weeks, indicated that use of testosterone significantly increased various aspects of sexual function such as sexual frequency, sexual desire, pleasure, and orgasms, irrespective of concurrent use estrogens, with no statistically significant increase in adverse events¹¹⁻¹³; and

Whereas, A double-blinded, placebo-controlled clinical trial with 53 postmenopausal women with low libido who were given 10 milligrams of testosterone gel per day for three months, in addition to their ongoing hormone replacement therapy, did not show any significant adverse effects and showed a positive effect on psychological well-being⁶; and

Whereas, Doses of testosterone therapy that approximate physiologically premenopausal concentrations in postmenopausal women have been associated with mild increase in acne, body and facial hair growth but not with hair loss, clitoromegaly or changes in voice, but safety data is not available beyond 24 months and further studies are needed to evaluate potential long-term adverse effects^{13,14}; and

1 Whereas, The effective dosage of testosterone for postmenopausal women has not been
2 elucidated, as a study of 71 surgically menopausal women suggested that positive change in
3 sexual function is achieved only with supraphysiologic dosing, while in 2019, a group of experts
4 from leading women's health societies worldwide published a consensus statement supporting
5 the benefit of testosterone therapy in doses that approximate physiologic concentrations in
6 premenopausal women^{14,15}; and

7
8 Whereas, Clinical practice guidelines published by the Endocrine Society and the American
9 College of Obstetricians and Gynecologists recommend a 3 to 6 month trial of testosterone
10 therapy for postmenopausal women with a diagnosis of HSDD, with close monitoring for
11 overuse and cessation of therapy if unresponsive after 6 months, but no current United States
12 Food & Drug Administration (FDA) approved testosterone treatments exist for women with
13 HSDD¹⁶; and

14
15 Whereas, Compounded and off-label medications such as flibanserin and bremelanotide have
16 been prescribed for many years for both men and women who want to boost levels of sexual
17 desire, arousal, and orgasm; however, these two medications received FDA approval for use in
18 pre-menopausal women only, in 2015 and 2019 respectively¹⁷; and

19
20 Whereas, Although there are many FDA-approved testosterone preparations for men, and
21 internationally accepted use of testosterone products in women, none are currently approved for
22 women in the United States, further highlighting gender biases in healthcare and medical
23 research that are evident from the incomplete understanding of pathophysiology of women's
24 sexual response and its treatment^{13,18}; and

25
26 Whereas, As evidenced by Code of Ethics 8.5 clause (i), the AMA supports "research that
27 examines health care disparities, including research on the unique health needs of all genders,
28 ethnic groups, and medically disadvantaged populations, and the development of quality
29 measures and resources to help reduce disparities;" and

30
31 Whereas, Due to the lack of FDA-approved medications for treating decreased libido in
32 postmenopausal women, physicians are often reluctant to prescribe medications unless
33 prompted by the patient and are forced to resort to modifying androgen formulations created for
34 men, which can make dosing difficult when using these preparations for postmenopausal
35 women^{17,18}; and

36
37 Whereas, Compounded or off-label medications like bremelanotide and flibanserin are
38 expensive for patients as they are not covered by insurance or available at discounted rates,
39 leaving many postmenopausal women to live with HSDD¹⁷; therefore be it

40
41 RESOLVED, That our American Medical Association encourage expansion of research on the
42 use of testosterone therapy and other pharmacological interventions in treatment of decreased
43 libido in postmenopausal individuals. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Code of Medical Ethics 8.5 Disparities in Health Care

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

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual 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.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level H-410.980

Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..

(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.

(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.

(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.

(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.

(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.

(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.

(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.

(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.

(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.

CMS Rep. D, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 523
(A-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee E

1 Whereas, Thirty-two million Americans, or 1 in 10, have at least one medical device¹; and

2
3 Whereas, A medical device is defined within the Food Drug & Cosmetic Act as "... an
4 instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other
5 similar or related article, including a component part, or accessory...intended for use in the
6 diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of
7 disease..., or intended to affect the structure or any function of the body...and which does not
8 achieve any of its primary intended purposes through chemical action...[and] is not dependent
9 upon being metabolized for the achievement of any of its primary intended purposes"²; and

10
11 Whereas, The Food and Drug Administration (FDA) has three regulatory classifications for
12 medical devices: Class I (minimal potential harm), Class II (moderate risk of harm), and Class III
13 (potential high risk of illness or injury)²⁻³; and

14
15 Whereas, The FDA approves the safety and efficacy of medical devices through three major
16 processes, one of which is Premarket Notification (PMN), also known as the 510(k) approval
17 pathway or 510(k) exception⁴; and

18
19 Whereas, The 510(k) approval pathway "is intended to support the FDA's public health mission
20 by meeting two important goals: making available to consumers devices that are safe and
21 effective, and fostering innovation in the medical device industry"⁵; and

22
23 Whereas, A Class II device can be cleared to market by submission and FDA review through
24 the 510(k) exception if that device is substantially equivalent to a "predicate device", even if the
25 "predicate device" had not been recently tested^{4,6,7}; and

26
27 Whereas, Using predicate devices for safety and efficacy standards may not accurately reflect
28 modern performance and safety standards⁸; and

29
30 Whereas, A number of devices approved via the 510(k) exception were later found to be less
31 efficacious than anticipated or even unsafe in their indicated usage, including transvaginal and
32 surgical meshes, metal-on-metal hip implants, and bioresorbable vascular scaffolds⁹⁻¹³; and

33
34 Whereas, Medical devices cleared through the 510(k) exception comprise more than two-thirds
35 of the products recalled by the FDA for safety concerns¹⁴; and

36
37 Whereas, There were attempts to improve the 510(k) pathway via the Safety of Untested and
38 New Devices Act of 2012 (SOUND Device Act) and again in 2019, but predicate devices have
39 remained the standard to evaluate device safety and efficacy^{15,16}; and

1 Whereas, One way to improve medical device standards is to mandate that 510(k) devices
2 demonstrate improved safety and effectiveness compared to marketed devices for the same
3 clinical purpose¹⁶; and
4

5 Whereas, Post-market surveillance is a critical component of medical device safety and
6 effectiveness because: 1) adverse events may not become apparent until the device has been
7 widely disseminated, and 2) increased emphasis on priority reviews and shortening premarket
8 approval times has decreased the standard of medical device approvals^{16,17}; and
9

10 Whereas, Current post-market surveillance only identifies a small fraction of adverse events
11 because it is based on mandated reports and passive surveillance¹⁶; and
12

13 Whereas, Post-market surveillance can be improved by giving conditional approval and
14 collecting data, including confirmatory trials¹⁶;
15

16 Whereas, Current policy (H-100.992) only outlines the AMA's position on approval processes for
17 biological drugs, but does not cover medical devices; therefore be it
18

19 RESOLVED, That our American Medical Association support improvements to the Food and
20 Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a)
21 make more stringent guidelines for which devices can qualify for the 510(k) exceptions; (b)
22 mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness
23 compared to market devices for the same clinical purpose (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA support stronger post-market surveillance requirements of medical
26 devices, including but not limited to (a): conditional approval of devices until sufficient post-
27 market surveillance data determining device safety can be collected, followed by confirmatory
28 trials, and (b) a publicly available summary of medical devices approved under expedited
29 programs along with associated clinical trial data and list of reported adverse events (New HOD
30 Policy); and be it further
31

32 RESOLVED, That our AMA amend policy H-100.992 to include medical devices by addition to
33 read as follows:
34

35 FDA, H-100.992

36 1. Our AMA reaffirms its support for the principles that:

37 (a) an FDA decision to approve a new drug or medical device, to withdraw a drug or
38 medical device's approval, or to change the indications for use of a drug or medical
39 device must be based on sound scientific and medical evidence derived from
40 controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket
41 incident reports as provided by statute;

42 (b) this evidence should be evaluated by the FDA, in consultation with its Advisory
43 Committees and expert extramural advisory bodies; and

44 (c) any risk/benefit analysis or relative safety or efficacy judgments should not be
45 grounds for limiting access to or indications for use of a drug or medical device unless
46 the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post
47 market reports shows that the drug or medical device is unsafe and/or ineffective for
48 its labeled indications. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Use of Remote Sensing & Monitoring Devices 1.2.9

Sensing and monitoring devices can benefit patients by allowing physicians and other health care professionals to obtain timely information about the patient's vital signs or health status without requiring an in-person, face-to-face encounter. Implantable devices can also enable physicians to identify patients rapidly and expedite access to patients' medical records. Devices that transmit patient information wirelessly to remote receiving stations can offer convenience for both patients and physicians, enhance the efficiency and quality of care, and promote increased access to care, but also raise concerns about safety and the confidentiality of patient information. Individually, physicians who employ remote sensing and monitoring devices in providing patient care should:

- (a) Determine whether using one or more such devices is appropriate in light of individual patients' medical needs and circumstances, including patients' ability to use the chosen device appropriately.
 - (b) Explain how the device(s) will be used in the patient's care and what will be expected of the patient in using the technology, and disclose any limitations, risks, or medical uncertainties associated with the device(s) and data transmission.
 - (c) Obtain the patient's or surrogate's informed consent before implementing the device in treatment.
- Collectively, physicians should:
- (d) Support research into the safety, efficacy, and possible non-medical uses of remote sensing and monitoring devices, including devices intended to transmit biometric data and implantable radio frequency ID devices.
 - (e) Advocate for appropriate oversight of remote sensing and monitoring devices.
- AMA Principles of Medical Ethics: I, III, V Issued: 2016

Reprocessing of Single-Use Medical Devices H-480.959

1. Our AMA: (a) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000; (b) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry; (c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.
 2. Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.
- CSA Rep. 3, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 217, I-17

Required Reporting of Adverse Events 8.8

Physicians' professional commitment to advance scientific knowledge and make relevant information available to patients, colleagues, and the public carries with it the responsibility to report suspected adverse events resulting from the use of a drug or medical device.

Mandated pre- and post-marketing studies provide basic safeguards for public health but are inherently limited in their ability to detect rare or unexpected consequences of use of a drug or medical device. Thus spontaneous reports of adverse events, especially rare or delayed effects or effects in vulnerable populations are irreplaceable as a source of information about the safety of drugs and devices. As the professionals who prescribe and monitor the use of drugs and medical devices, physicians are best positioned to observe and communicate about adverse events.

Cases in which there is clearly a causal relationship between use of a drug/device and an adverse event, especially a serious event, will be rare. Physicians need not be certain that there is such an event, or even that there is a reasonable likelihood of a causal relationship, to suspect that an adverse event has occurred. A physician who suspects that an adverse reaction to a drug or medical device has occurred has an ethical responsibility to:

- (a) Communicate that information to the professional community through established reporting mechanisms.
- (b) Promptly report serious adverse events requiring hospitalization, death, or medical or surgical intervention to the appropriate regulatory agency.

AMA Principles of Medical Ethics: I, V, VII Issued: 2016

Use of Wireless Radio-Frequency Devices in Hospitals H-215.972

Our AMA encourages: (1) collaborative efforts of the Food and Drug Administration, American Hospital Association, American Society for Healthcare Engineering, Association for the Advancement of Medical Instrumentation, Emergency Care Research Institute, and other appropriate organizations to develop consistent guidelines for the use of wireless radio-frequency transmitters (e.g., cellular telephones, two-way radios) in hospitals and standards for medical equipment and device manufacturers to ensure electromagnetic compatibility between radio-frequency transmitters and medical devices; and that our AMA work with these organizations to increase awareness among physicians and patients about electromagnetic compatibility and electromagnetic interference in hospital environments;

- (2) hospital administrators to work with their clinical/biomedical engineering staff, safety committees, and other appropriate personnel to adopt and implement informed policies and procedures for (a) managing the use of wireless radio-frequency sources in the hospital, particularly in critical patient care areas; (b) educating staff, patients, and visitors about risks of electromagnetic interference (EMI); (c) reporting actual or suspected EMI problems; and (d) testing medical devices for susceptibility to EMI when electromagnetic compatibility information is lacking;
- (3) medical device and electronic product manufacturers to design and test their products in conformance with current electromagnetic immunity standards and inform users about possible symptoms of electromagnetic interference (EMI). If a possibility of EMI problems affecting medical devices exists, steps should be taken to ensure that all sources of electromagnetic energy are kept at sufficient distance; and
- (4) physicians to become knowledgeable about electromagnetic compatibility and electromagnetic interference (EMI), recognize EMI as a potential problem in hospital environments, and report suspected EMI problems to the Food and Drug Administration MedWatch program or appropriate hospital personnel.

CSA Rep 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Medical Device Safety and Physician Responsibility H-480.972

The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use.

Res. 507, I-95; Res. 509, A-96; Appended: Res. 504, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Guidelines for Mobile Medical Applications and Devices D-480.972

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.

CSAPH Rep. 5, A-14; Appended: Res. 201, A-15; Appended: Res. 305, I-16; Modified: Res. 903, I-19

Interoperability of Medical Devices H-480.953

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

Res. 519, A-09; Reaffirmation: I-15; Reaffirmed: BOT Rep. 05, I-16

Medical Device "Use Before Dates" D-480.977

Our AMA will encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the "use before date" for medical devices.

Res. 508, A-12

Access to Medical Care D-480.991

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

Res. 130, A-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945

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

BOT Action in response to referred for decision Res. 502, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Protecting Social Media Users by Updating FDA Guidelines D-105.995

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

Res. 209, I-15

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
 2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
 3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
 4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
 5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
 6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.
- Res. 30, A-88, Reaffirmed: BOT Rep. 53, A-94, Reaffirmed and Modified: CSA Rep. 3, A-97, Reaffirmed and Modified: Res. 528, A-99, Reaffirmed: CMS Rep. 8, A-02, Reaffirmed: CMS Rep. 6, A-03, Modified: Res. 517, A-04, Reaffirmation, I-07, Reaffirmed: Res. 819, I-07, Reaffirmation, A-09, Reaffirmation, I-10, Modified: BOT Rep. 5, I-14, Reaffirmed: Res. 505, A-15, [Reaffirmed: CMS Rep. 6, I-20](#); Reaffirmed: Res. 509, I-20

Registry of Implantable Devices H-480.986

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

BOT Rep. JJ, A-90, Reaffirmed: Sunset Report I-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Latex Allergy Warning H-480.970

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

Sub Res. 502, A-96, Appended Res. 504, I-97, Reaffirmed: CSAPH Rep. 3, A-07, Reaffirmed: CSAPH Rep. 01, A-17

Physicians and Clinical Trials D-460.979

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

Res. 610, I-04, Modified: CSAPH Rep. 1, A-14

Availability of Professionals for Research H-460.982

(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased

funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.

BOT Rep. NN, A-87, Reaffirmed: Sunset Report, I-97, Reaffirmed: CSA Rep. 13, I-99, Reaffirmed: CME Rep. 4, I-08, Modified: Res. 305, A-12, Modified: CME Rep. 2, A-12

Comparative Effectiveness Research H-460.909

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

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

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

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

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

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

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

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

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

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

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

CMS Rep. 5, I-08, Reaffirmed: Res. 203, I-09, Reaffirmation: I-10, Reaffirmed: CMS Rep. 05, I-16, Reaffirmed: CMS Rep. 4, I-19

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
 2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
 3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.
- Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-22)

Introduced by: Medical Student Section

Subject: Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings

Referred to: Reference Committee E

1 Whereas, There has been a recent 43% increase in incidence of mild traumatic brain injuries
2 (TBIs) in the United States in both non-athletic and athletic populations¹; and
3

4 Whereas, The Centers for Disease Control and Prevention (CDC) acknowledges that non-
5 athletic TBIs affect diverse patient populations^{2,3}; and
6

7 Whereas, 64.4% of TBIs are non-sports related, caused by activities of daily living, traffic or
8 work-related accidents, falls, motor vehicle crashes, recreation, acts of interpersonal violence,
9 and blast injuries^{4,5,6}; and
10

11 Whereas, Studies show that adult patients with non-athletic TBIs experience increased mortality
12 rates and long-term consequences such as increased incidence of post-concussion symptoms⁷;
13 and
14

15 Whereas, A study by the Center for Disease Control suggests that rates of pediatric
16 hospitalization and death are higher in non-athletes compared to that of athletic brain injuries
17 due to a lack of early intervention^{7,8,9,10}; and
18

19 Whereas, Approximately 48% of patients are lost to follow-up three months after hospitalization
20 for TBIs¹¹; and
21

22 Whereas, Almost 88% victims of domestic violence survivors suffer TBIs, which can lead to
23 devastating and permanent physical, behavioral, and cognitive consequences¹²; and
24

25 Whereas, Due to a lack of universally accepted diagnostic criteria, clinicians rely on likely
26 mechanism of injury for diagnosis of TBI, which may delay care for victims of domestic violence
27 who often do not report their injuries^{12,13}; and
28

29 Whereas, Victims of domestic violence often face unstable social situations, homelessness, and
30 impaired cognitive states as a result of years of repeated brain injury, thus when they do seek
31 medical care for their injuries, they experience added barriers to follow-up care, such as
32 transportation, communication, and education¹²; and
33

34 Whereas, 89% of women experiencing an intimate partner violence-related TBI reported post-
35 concussion syndrome, and early intervention for victims of domestic violence with mild TBIs are
36 correlated with a reduction in post-concussive and other residual symptoms^{14,15}; and
37

38 Whereas, Due to longer time to admission for acute-injury admissions, ethnic minorities,
including those with history of homelessness and incarceration, experience inequity in post-

1 injury rehabilitation, and are less likely to obtain post-injury hospital admission compared to
2 Non-Hispanic White patients^{16,17}; and

3
4 Whereas, When the severity of injury may not differ significantly between patients of color and
5 white patients, there are non-medical factors including systemic and environmental barriers
6 contributing to the delay in access to acute TBI-rehabilitation in patients of color¹⁶; and

7
8 Whereas, Patients with non-athletic TBI are more likely to seek treatment via primary care
9 providers¹³; and

10
11 Whereas, Over the past year, only 12–23% of adult female victims report to seeking treatment
12 from their primary care physician for their injuries and subsequent morbidity after experiencing
13 intimate partner violence¹⁸; and

14
15 Whereas, Patients who access primary care physicians for post-TBI care may be less likely to
16 receive equitable treatment compared to athletes who have access to athletic trainers, coaches,
17 and specialty physicians with return-to-play models of treatment ^{19,20}; and

18
19 Whereas, Primary care providers who were trained by the CDC's Heads Up program on TBIs
20 were able to improve their patients' rate of treatment success and symptom recovery^{13,21}; and

21
22 Whereas, Providing patients with information emphasizing the importance of post-injury care,
23 encouraging interdisciplinary collaboration, and equipping primary physicians with the tools
24 needed for appropriate treatment and referral services improves patients' functional recovery
25 and treatment success²²; and

26
27 Whereas, The treatment tools provided to primary care physicians include screening for
28 neurosurgical emergencies or cervical spine injury and targeted treatment for specific symptoms
29 of post-injury headaches, sleep disturbance, and psychological distress through medication and
30 environmental and behavioral changes^{13,23}; and

31
32 Whereas, The AMA recognizes the need for TBI prevention and remediation of post-injury
33 morbidities (H-470.954); and

34
35 Whereas, Current AMA policy does not emphasize ethnic minorities or victims of domestic
36 violence in existing policy for TBIs, nor does it address post-injury rehabilitation in non-athletic
37 injuries; therefore be it

38
39 RESOLVED, That our American Medical Association recognize disparities in the care for
40 traumatic brain injuries, and acknowledge non-athletic traumatic brain injuries as a significant
41 cause of morbidity and mortality, particularly for ethnic minorities and victims of domestic
42 violence; (New HOD Policy) and be it further

43
44 RESOLVED, That our AMA support increased access to traumatic brain injury resources in
45 primary care settings which advocate for early intervention, encourage follow-up retention of
46 patients for post-injury rehabilitation, and improved patient quality of life. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY**H-470.954 Reduction of Sports Related Injury and Concussion**

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
 4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
 5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
- CSAPH Rep. 3, A-15; Appended: Res. 905, I-16

H-470.984 Brain Injury in Boxing

The AMA supports the following series of steps designed to protect amateur and professional boxers from injuries:

- (1) Encourage the establishment of a "National Registry of Boxers" for all amateur and professional boxers, including "sparring mates," in the country. The proposed functions of a computer-based central registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and other boxing injuries, and to compile injury and win/loss records for individual boxers.
- (2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his opinion, result in serious injury for either contestant.
- (3) Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.
- (4) Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.
- (5) Inform state legislatures that unsupervised boxing competition between unlicensed boxers in "tough man" contests is a most dangerous practice that may result in serious injury or death to contestants, and should be condemned.
- (6) Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic safety mats and padded cornerposts, and to encourage continued development of safety equipment.
- (7) Urge state and local boxing commissions to extend all safety measures to sparring partners.
- (8) Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical evaluations for boxers.

CSA Rep. F, A-82; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: Sub. Res. 408, I-93; Reaffirmed: CSA Rep. 3, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 3, A-15

H-515.965 Family and Intimate Partner Violence

- (1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
- (2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
- (3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency

situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Continuing Equity Education

Referred to: Reference Committee F

Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice through the adoption and implementation of policies, processes, and programs that center equity, such as the founding of the AMA Center for Health Equity and adoption of several racial justice and equity-oriented policies by the House of Delegates¹; and

Whereas, In May 2021, the Center for Health Equity released its three-year organizational strategic action plan to embed racial justice and advance health equity within the AMA and across medicine, and has since taken the initial steps to operationalize this mission, including the collaborative release of *Advancing Health Equity: A Guide to Language, Narrative and Concepts* to provide a shared framework for the discussion of health equity issues²⁻⁴; and

Whereas, In response to member requests to expand and deepen their understanding of health equity and racial justice, the AMA Board of Trustees and Speakers arranged for the convening of an Open Forum on Health Equity during the November 2021 (N21) Special Meeting of the House of Delegates (HOD) to facilitate additional opportunities for education and discussion among membership^{5,6}; and

Whereas, The N21 Health Equity Forum granted HOD members a safe environment to participate in curated education sessions and programming with health equity experts and scholars, providing information exchange and valuable perspective into the importance of learning life-long skills and furthering knowledge to prioritize equity; therefore be it

RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000; however, honoraria and/or speakers' fees may result in significantly larger and variable annual cost.

Received: 05/09/22

References:

1. Keelys M, Baca J, Maybank A. Race, Racism, and the Policy of 21st Century Medicine. *Yale J Biol Med*. 2021;94(1):153-157
2. American Medical Association. AMA releases plan dedicated to embedding racial justice and advancing health equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing>
3. American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>
4. Association of American Medical Colleges. American Medical Association. Advancing Health Equity: A Guide to Language, Narrative, and Concepts. Published October 28, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf>
5. Kridel, R. A Communication from the Board Chair. *American Medical Association*. June 1, 2021.
6. Scott, B, Egbert, L. Speakers' Letter Special Meeting of the AMA House of Delegates November 12-16, 2021. *American Medical Association*. October 12, 2021.

RELEVANT AMA POLICY

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

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

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

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Our AMA adopted 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 should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or

encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.

- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Citation: Res. 003, A-21

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

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; (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; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes 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.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

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.

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; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

Citation: CME Rep. 5, A-21

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 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; Modified: CME Rep. 5, A-21

Training Physicians and Physicians-in-Training in the Art of Public Speaking H-445.984

1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources

that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program.

Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature.

Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking.

2. Our AMA will offer live education sessions at least annually for AMA members to develop their public speaking skills.

Citation: BOT Rep. 10, I-18

Activities of the Council on Legislation G-615.071

1. Our AMA Council on Legislation (COL) will continue to convene forums at AMA meetings to provide members of the Federation an opportunity to hear about and discuss major and emerging legislative and regulatory issues important to physicians and patients.

2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the State Legislative Strategy Conference and National Advocacy Conference.

3. COL members will actively represent, at the discretion of the Chair of the Board of Trustees, our AMA before state and federal government committees and agencies.

Citation: (BOT Rep. 12, A-07; Reaffirmed: BOT Rep. 4, I-10; Modified: CCB/CLRPD Rep. 3, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce

Referred to: Reference Committee F

Whereas, Our AMA established policy permits coordination and transfer of voluntarily provided racial data from the Association of American Medical Colleges (AAMC) to the AMA Physician Masterfile, which includes current and history data for more than 1.4 million physicians, fellows, residents, and medical students in the United States; and

Whereas, AAMC applications such as AMCAS, MCAT, and ERAS utilize a two-tier analysis for race data, with tier one presenting the data by race only when one race is selected, and all others as “two or more races” (ensuring no student is counted more than once), with tier two presenting data by race, including any student who indicated a racial category whether alone or “in combination” with other races (ensuring medical schools, residency, and fellowship programs have an accurate count of students who identify as each race);¹ and

Whereas, The U.S. Department of Education (DOE) race reporting requirements only has the first tier of race reporting, which therefore excludes reporting any race data for respondents who indicate more than one race;² and

Whereas, AAMC data illustrates an example of how disparate DOE race data requirements are, with the 1,010 current US medical students who identify as American Indian/Alaska Native (AI/AN), 17% report AI/AN as their only race, meaning that under DOE race requirements, 83% of AI/AN students would have no race data reported;³ and

Whereas, The inconsistency of the data between pre-medical students and medical students due to these divergent policies can contribute to difficulties identifying problem areas where additional support could improve underrepresented students’ chances of becoming a medical student, resident/fellow, and finally a practicing physician; therefore be it

RESOLVED, That our American Medical Association adopt racial and ethnic demographic data collection practices that allow self-identification of designation of one or more racial categories (Directive to Take Action); and be it further

RESOLVED, That our AMA report demographic physician workforce data in mutually exclusive categories of race and ethnicity whereby Latino, Hispanic, and Other Spanish ethnicity and Middle Eastern North African ethnicity are categories, irrespective of race (Directive to Take Action); and be it further

1 RESOLVED, That our AMA adopt racial and ethnic physician workforce demographic data
 2 reporting practices that permit disaggregation of individuals who have chosen multiple
 3 categories of race so as to distinguish each category of individuals' demographics as alone or in
 4 combination with any other racial and ethnic category (Directive to Take Action); and be it
 5 further
 6

7 RESOLVED, That our AMA collaborate with AAMC, ACGME, AACOM, AOA, NBME, NBOME,
 8 NRMP, FSBM, CMSS, ABMS, HRSA, OMB, NIH, ECFMG, and all other appropriate
 9 stakeholders, including minority physician organizations, and relevant federal agencies to
 10 develop standardized processes and identify strategies to improve the accurate collection,
 11 disclosure and reporting of racial and ethnic data across the medical education continuum and
 12 physician workforce. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$150K-\$175K.

Received: 05/09/22

References:

1. Association of American Medical Colleges. FACTS Glossary. 2021. Accessed May 2, 2022. <https://www.aamc.org/data-reports/students-residents/interactive-data/facts-glossary>
2. Office of Management and Budget. (1997b) Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register: 62: No.210, October 30.
3. Association of American Medical Colleges. 2021 FACTS: Enrollment, Graduates, and MD-PhD Data. Accessed May 2, 2022. <https://www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-enrollment-graduates-and-md-phd-data>

RELEVANT AMA POLICY

Race and Ethnicity as Variables in Medical Research H-460.924

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

Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 01, A-21

Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent D-350.979

Our AMA will: (1) add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients.

Citation: Res.19, I-21

AMA Race/Ethnicity Data D-630.972

Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.

Citation: (BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12)

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

Citation: Res. 03, I-19

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
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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 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; Modified: CME Rep. 5, A-21

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.

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; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education;

(2) 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; (3) 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; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

Citation: Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21

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.

Citation: Res. 018, A-17

Racial and Ethnic Identity Demographic Collection by the AMA D-350.982

Our AMA will develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students.

Citation: Res. 614, A-19

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

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

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; (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; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes 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.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

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

National Resident Matching Program Reform D-310.977

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) 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 (ACGME) 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 NRMP and 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;

(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; and

(18)

encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(A-22)

Introduced by: California

Subject: Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee

Referred to: Reference Committee F

Whereas, Resolution 605 from N-21 regarding establishment of a Resolution Committee was referred to the Board of Trustees for study without specified timing for report back to the House of Delegates; and

Whereas, The subject matter of Resolution 605 from N-21 is of significant interest and importance to the House of Delegates; therefore be it

RESOLVED, That the Report of the Board of Trustees regarding Resolution 605 from N-21 be presented to the American Medical Association House of Delegates with recommendation(s) for the House of Delegates to be voted upon at the 2022 Interim Meeting. (Directive to Take Action)

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

Received: 05/09/22

Resolution 605 (N-21): Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates was **referred** by the N-21 House of Delegates.

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(A-22)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for
AMA Office

Referred to: Reference Committee F

1 Whereas, In Year 1 of the COVID-19 pandemic (in accordance with AMA election guidelines),
2 the Endocrine Section Council of the American Medical Association conducted virtual interviews
3 for 7 of 8 candidates for AMA Board of Trustees and all 5 candidates for AMA Council on
4 Medical Service on Sat., 30 May, 2020 (and the one BOT candidate with a conflict was able to
5 meet virtually on an alternate and mutually-convenient date); and
6

7 Whereas, In Year 2 of the COVID-19 pandemic (and in accordance with AMA election
8 guidelines), the Endocrine Section Council of the AMA conducted virtual interviews for all 12
9 candidates for AMA President-elect, AMA Board of Trustees, the AMA Council on Science and
10 Public Health, the AMA Council on Constitution and Bylaws, and the AMA Council on Medical
11 Service on Sat., 22 May, 2021; and
12

13 Whereas, In Year 3 of the COVID-19 pandemic, and in response to action by the AMA House of
14 Delegates, all virtual interviews for Candidates for AMA Elections (President-elect, Board of
15 Trustees, and all Councils) were required to be held between Thur., 26 May-Sun., 29 May,
16 which was over Memorial Day weekend; and
17

18 Whereas, In 2022, seven groups have offered virtual interviews to candidates for AMA Office;
19 and
20

21 Whereas, Virtual interviews allow caucuses to meet candidates for AMA Office before the in-
22 person meeting, without the distractions of AMA business and policy-making, networking, and
23 catching up with old friends; and
24

25 Whereas, Virtual interviews allow candidates for AMA office to hone their speeches and
26 presentations before the in-person meeting; and
27

28 Whereas, Current AMA-HOD policy states that: "Interviews may be conducted only during a
29 window beginning on the Thursday evening two weeks prior to the scheduled Opening Session
30 of the House of Delegates meeting at which elections will take place and must be concluded by
31 that Sunday (four days later);" and
32

33 Whereas, Memorial Day weekend is a decidedly inconvenient time to conduct virtual interviews,
34 making "work-life balance" even more difficult (for both candidates and caucuses alike);
35 therefore be it

1 RESOLVED, That our AMA amend policy G-610.020, "Rules for AMA Elections," by addition
2 and deletion to read as follows:

3
4 Interviews may be conducted only during a window designated by the Speaker
5 beginning on the Thursday evening of a non-holiday weekend at least two weeks
6 but not more than 4 weeks prior to the scheduled Opening Session of the House of
7 Delegates meeting at which elections will take place and must be concluded by
8 that following Sunday ~~(four days later)~~. (Modify Current HOD Policy)

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

Received: 05/11/22

REFERENCES:

1. 2022 AMA Elections Manual

RELEVANT AMA POLICY

Rules for AMA Elections G-610.020

- (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.
- (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election .
- (3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker.
- (4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

(5) The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting.

(7) The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.

(8) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

(9) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.

(10) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

- a. Interviews may be arranged between the parties once active campaigning is allowed.
- b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

- i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
 - ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
 - iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.
 - c. Groups may elect to conduct interviews virtually or in-person.
 - d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
 - e. Virtual interviews are subject to the following constraints:
 - i. Interviews may be conducted only during a window beginning on the Thursday evening two weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by that Sunday (four days later).
 - ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
 - iii. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
 - f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
 - g. Recordings of interviews may be shared only among members of the group conducting the interview.
 - h. A candidate is free to decline any interview request.
 - i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
- (13) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.
- (14) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.
- (15) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.
- (16) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.
- (17) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
- (18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.
- (19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

(20) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.

(21) Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

(22) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

(23) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

(24) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.

(25) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Citation: CLRPD Rep. E, I-80; Res. 22, I-81; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CLRPD Rep. F, I-91; CCRC Special Report, I-92; CCRC Special Report I-93; Special Committee on Campaign and Elections and Reaffirmed Special Committee Report on Campaigns and Elections, I-96; Special Committee on Campaigns and Elections, A-97; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; CC&B Rep. 3, I-08; Modified: Rules and Credentials Rep. 1, A-11; Modified: Rules and Credentials Rep. 1, I-13; Appended: BOT Rep. 5, I-13; Modified: Res. 602, A-14; Modified: Speakers Rep. 1, I-14; Modified: Res. 1, A-15; Modified: Speakers Rep. 2, A-21; Modified: Speakers Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(A-22)

Introduced by: Medical Student Section

Subject: Anti-Harassment Training

Referred to: Reference Committee F

1 Whereas, The 2018 National Academies of Science, Engineering, and Medicine (NASEM)
2 report on sexual harassment in academia defines sexual harassment as “composed of three
3 categories of behavior: (1) gender harassment (verbal and nonverbal behaviors that convey
4 hostility, objectification, exclusion, or second-class status about members of one gender), (2)
5 unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include
6 assault), and (3) sexual coercion (when favorable professional or educational treatment is
7 conditioned on sexual activity)”, whether directly targeted towards an individual or ambient¹; and
8

9 Whereas, Gender-based discrimination and bias are widespread in the medical professional
10 workspace, with the rate of sexual harassment in academic medicine being close to double that
11 of other engineering and science fields^{2,3}; and
12

13 Whereas, Among female trainees, approximately 45% experience at least one instance of
14 gender harassment through sexist hostility, and 18% have experienced crude, sexist behavior,
15 and male trainees report 21% and 10% rates respectively¹; and
16

17 Whereas, The 2018 NASEM report concludes that “the cumulative effect of sexual harassment
18 is a significant and costly loss of talent in academic science, engineering, and medicine,
19 which has consequences for advancing the nation’s economic and social well-being and its
20 overall public health”¹; and
21

22 Whereas, Victims of sexual harassment often will not report the harassment to their institutions
23 because of fear of retaliation such as being “labeled as a troublemaker”⁴; and
24

25 Whereas, The U.S. Supreme Court recognizes claims for sexual harassment as a form of
26 discrimination based on sex under Title VII of the Civil Rights Act of 1964⁵; and
27

28 Whereas, The Equal Employment Opportunity Commission’s Select Task Force on the Study of
29 Harassment in the Workplace formed by the U.S. Equal Opportunity Employment Commission
30 in their executive report stated: “The importance of leadership cannot be overstated – effective
31 harassment prevention efforts, and workplace culture in which harassment is not tolerated, must
32 start with and involve the highest level of management of the company”⁶; and
33

34 Whereas, *Sexual Harassment of Women: Climate, Culture and Consequences in Academic*
35 *Science, Engineering and Medicine* states that “organizational tolerance for sexually harassing
36 behavior” increases the risk of sexual harassment occurring within the organization¹; and
37

38 Whereas, Sexual harassment in the professional environment leads to a well-documented loss
39 of productivity and attrition of workers^{1,7,8}; and

1 Whereas, A study published in *Academic Medicine* stated that it is imperative to have senior
2 faculty and leadership call out inappropriate behaviors and sexual harassment to serve as role
3 models for their colleagues, trainees, and staff⁴; and
4

5 Whereas, The American Association of Medical Colleges (AAMC) encourages a culture change
6 as a way to address harassment, which includes training individuals of all genders in bystander
7 intervention³; and
8

9 Whereas, Real-world and experimental evidence shows that the way leadership communicates
10 about sexual assault and sexual harassment strongly influences an organization or group's
11 attitudes toward sexual harassment and violence, with leadership emphasis on addressing
12 sexual harassment resulting in group participants rating the priority of addressing harassment
13 higher^{9,10,11}; and
14

15 Whereas, Among those who do report sexual harassment to their employers, nearly half report
16 being dissatisfied with the response¹²; and
17

18 Whereas, Given that the result of sexual harassment is a net loss of talent and highly trained
19 personnel, the costs of not aggressively addressing sexual harassment in medicine and
20 organized medicine are substantial¹; and
21

22 Whereas, Our AMA has a zero-tolerance policy for sexual harassment and expects members to
23 act with decorum at meetings according to the Code of Conduct (H-140.837) and the AMA Code
24 of Medical Ethics (9.1.3) explicitly states that sexual harassment is unethical, however there is
25 no formal training in the AMA on how to prevent/counter sexual harassment or advise members
26 when it occurs;¹³ and
27

28 Whereas, Our AMA has demonstrated a financial commitment to reducing sexual harassment
29 through previously utilizing outside resources to strengthen our AMA's policies and protections
30 of all AMA members¹⁴; and
31

32 Whereas, Our AMA has created a Continuing Medical Education module to address sexual
33 harassment in medicine, especially between physicians and their patients¹⁵; therefore be it
34

35 RESOLVED, That our American Medical Association require all members elected and
36 appointed to national and regional AMA leadership positions to complete AMA Code of Conduct
37 and anti-harassment training, with continued evaluation of the training for effectiveness in
38 reducing harassment within the AMA (Directive to Take Action); and be it further
39

40 RESOLVED, That our AMA work with the Women Physician Section, American Medical
41 Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other
42 stakeholders to identify an appropriate, evidence-based anti-harassment and sexual
43 harassment prevention training to administer to leadership. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$60K - \$65K.

Received: 05/11/22

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RELEVANT AMA POLICY**Policy on Conduct at AMA Meetings and Events H-140.837**

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact. Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate. These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator. Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18; Modified: BOT Rep. 10, A-19; Modified: CCB Rep. 2, I-20

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II, IV, VII

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Res. 010, A-18; Modified: BOT Rep. 27, A-19

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Res. 005, A-18

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972

It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(A-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee F

1 Whereas, Over 90% of physicians surveyed in 2006 rated political involvement and collective
2 advocacy as important¹; and
3

4 Whereas, Civic engagement from medical professionals has been identified to improve
5 medicine's relationship with society²⁻⁴; and
6

7 Whereas, Voting is a constitutional right and is considered the most basic expression of civic
8 participation, and voting has been shown to have a relationship with other civic behaviors, even
9 suggesting a causative relationship between voting and civic engagement^{5,6}; and
10

11 Whereas, National physician voter registration rates have been documented as high as 94%,
12 and a study of residents and fellows suggests that up to 88% may be registered to vote^{7,8}; and
13

14 Whereas, Despite high rates of registration, physician voter turnout suggests physicians vote at
15 a rate lower than that of the general population and much lower than that of other white-collar
16 professions, with physicians' 22% turnout being lower than that of lawyers⁹; and
17

18 Whereas, Among the general public, such as statewide portable voter registration, which can
19 increase voter turnout by 2.4%; election day registration, which can increase voter turnout by 3-
20 6%; and the institution of mail-in ballots, which resulted in a 10% increase in voter turnout in
21 Oregon in both presidential and midterm elections¹⁰⁻¹²; and
22

23 Whereas, In a survey of residents and fellows, 94% agreed that they had the duty to advocate,
24 yet only 13% felt comfortable influencing legislation on a particular legislative issue⁸; and
25

26 Whereas, Medical students are eager to participate in the political process and view addressing
27 healthcare policy as a professional responsibility¹³; and
28

29 Whereas, Medical student voter participation has the potential to be highly influential on the
30 future of healthcare in our society and it is important to allot the time needed for engagement in
31 important historic events¹³; and
32

33 Whereas, Voter turnout is dependent on ability and ease of voting and conflicting work or school
34 schedule is consistently one of the top reasons registered nonvoters report for not voting¹⁴⁻¹⁶;
35 and
36

37 Whereas, Many medical students feel that their schools do not adequately allocate time for
38 students to vote and participate in the political process¹⁷; and

Whereas, AMA policy grants time off for resident involvement in organized medicine (H-310.911) and supports education of medical trainees on health policy, advocacy, and legislative issues that affect medical trainees and physicians (H-295.953), but does not address barriers that prevent medical students from voting; and

Whereas, The AMA endorses identifying efforts to engage physicians and medical trainees in legislative advocacy (G-615.103), the physician and medical trainee's right to engage in patient advocacy (H-285.910, H-225.950), as well as the fundamental importance of advocacy in the physician-patient relationship (H-225.950), yet no efforts are focused on identifying and alleviating barriers to medical student, resident/fellow, and physician voting; therefore be it

RESOLVED, That our American Medical Association study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools. (Directive to Take Action)

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

Received: 05/11/22

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

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

Res. 608, A-17

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

Res. 8, A-11, Reaffirmed: CEJA Rep. 1, A-21

ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities H-310.911

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

Res. 317, A-11; Reaffirmed: CME Rep. 1, A-21

AMA Principles for Physician Employment H-225.950**1. Addressing Conflicts of Interest**

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

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

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

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

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

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

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

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

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

6. Payment Agreements

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

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

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

BOT Rep. 6, I-12, Reaffirmed: CMS Rep. 6, I-13, Modified in lieu of Res. 2, I-13, Modified: Res. 737, A-14, Reaffirmed: BOT Rep. 21, A-16, Reaffirmed: CMS Rep. 05, A-17, Reaffirmed: CMS Rep. 7, A-19, Reaffirmed: CMS Rep. 11, A-19, Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(A-22)

Introduced by: Medical Student Section

Subject: Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

Referred to: Reference Committee F

Whereas, Meeting attendance and participation is an important and impactful part of student participation in the AMA, allowing students to connect with colleagues and with physician leaders, and mentors, which helps students find ways to stay involved in their future careers; and

Whereas, Of indebted medical students, the mean educational debt of the medical school class of 2021 was \$203,062¹; and

Whereas, Cost is a significant barrier to student participation in the AMA's biannual meetings of the MSS and HOD, in which the AMA-MSS generally meets for two to three days prior to the House of Delegates (HOD) which meets for three or four additional days, with costs for the most recent in-person Annual and Interim HOD meetings as follows:

- Travel:
 - ~\$350-550 round-trip airfare for each A-19 and I-19 trips, individually.²
 - [Airport Transportation To/From Hotel 2019 HOD Meeting](#): \$35 One way; \$50 Two way.³
 - Hawaii-based meetings: ~\$670s-\$820s round-trip airfare.⁴
- Lodging:
 - 2019 Annual Meeting (Hyatt Regency in Chicago, IL):
 - Single: \$255 per night plus tax = \$299.34 per night
 - Double: \$280 per night plus tax = \$328.69 per night
 - 2019 Interim Meeting (Manchester Grand Hyatt and Marriott Marquis in San Diego, CA):
 - \$285 per night plus tax = \$321.28 per night.³
- Food:
 - 2019 Annual Meeting:
 - Chicago: \$34/day.⁶
 - [2019 Interim Meeting](#):
 - San Diego: \$33/day.⁵

Whereas, All medical students are encouraged to attend the AMA-MSS meeting, and at least one delegate and alternate delegate from every medical school is expected to be at the assembly, and the HOD assembly is attended by student representatives from each region based on total region membership, in addition to student councilors, a section delegate and alternate delegate (MSS Internal Operating Procedures 10.4 through 10.4.6; AMA Bylaws 2.3 through 2.3.6, 7.3.3 through 7.3.4.3), and MSS registrants at the A-19 MSS Meeting was 620 members and at the I-19 MSS Meeting was 711 members (data provided by staff); and

1 Whereas, In addition to the AMA-MSS Annual and Interim meetings, medical student members
2 may also participate in additional advocacy or region-specific conferences that require travel,
3 such as the AMA Medical Student Advocacy Conference (in Washington, DC) and Region-
4 specific Physicians of the Future Summits (held in various locations within each geographic
5 region); and
6

7 Whereas, Some MSS Regional Delegates and Alternate Regional Delegates to the HOD
8 receive financial support from their state delegations, but a 2022 survey of the MSS Caucus
9 showed that 51% of these delegates are receiving funding for travel and hotel, 12% for hotel
10 only, and 37% receive no state funding; and
11

12 Whereas, Many organizations provide funding for students to participate in their meetings, for
13 example:

- 14 • the American College of Radiology (ACR) offers up to 15 stipends of \$150 to qualified
15 medical students attending the ACR annual meeting when virtual⁷
- 16 • the American Academy of Family Physicians (AAFP) provides 250 scholarships of \$600
17 to attend their national conference^{8,9}
- 18 • the American Medical Women's Association (AMWA) gives scholarships to students and
19 has special consideration to students with leadership positions, presenting posters,
20 ambassadors, or who are traveling from far-away locations¹⁰
- 21 • the American Psychiatric Association (APA) provides up to 30 medical students variable
22 funding to attend both the Annual Meeting and the Mental Health Services Conference¹¹
23 and specifically seeks to support underrepresented minority and racial/ethnic students
- 24 • the Society for Vascular Surgery (SVS) and American Academy of Neurology (AAN) also
25 offer travel awards specifically focused on diverse student populations in addition to a
26 general award^{12,13}; and
27

28 Whereas, A study of the AAFP's funding mechanism and conference attendance demonstrated
29 that systematic programs to fund student participation in conferences increased attendance and
30 likelihood of future conference attendance⁹; and
31

32 Whereas, For general AMA-MSS members, until spring 2021 the sole AMA funding source for
33 travel was the Medical Student Outreach Program (MSOP) Recruitment Commission; MSOP is
34 a peer-to-peer mentorship initiative designed to promote first year medical student recruitment
35 and engagement and based on recruitment numbers from early April 2021, the average
36 Recruitment Commission per school would be around \$550; median around \$250^{14,15}; and
37

38 Whereas, In March 2021, the AMA announced a new travel scholarship, for up to \$1,000, for
39 one student from each MSS Region (seven students total), to be awarded for the first time for
40 the Annual 2022 Meeting, and as a part of the AMA Section Involvement Grant, MSOP
41 instituted an AMA Annual Meeting Travel Grant for students to attend the MSS June 2022
42 Meeting^{16,17}; and
43

44 Whereas, The AMA Ambassador Program provides leadership and networking opportunities for
45 MSS members, including scholarships to attend and be trained at AMA advocacy
46 conferences¹⁸; and
47

48 Whereas, Besides the data from the informal poll above, data on student funding for meetings
49 are not available, and likewise neither are data on financial or other barriers to student
50 participation in AMA meetings; and

Whereas, Our AMA is dedicated to the professional development of student, resident and fellow, and young physician section representatives (G-600.030); therefore be it

RESOLVED, That our American Medical Association explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Diversity of AMA Delegations G-600.030

Our AMA encourages: (1) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (2) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (5) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.

CCB/CLRPD Rep. 3, A-12

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; Reaffirmed: CME Rep. 5, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary

medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in 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 employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's 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; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to

successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

Financial Aid to Medical Students H-305.999

Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students.

Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20

AMA Bylaws**AMA Bylaws 2.3 through 2.3.6, 7.3.3 through 7.3.4.3**

2.3 Medical Student Regional Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, regional medical student delegates and alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical Student Regional delegates and alternate delegates must be active medical student members of the AMA.

2.3.2 Apportionment. The total number of Medical Student Regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining Medical Student Section Regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the MSS Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the Medical Student Section Governing Council of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical Student Regional delegates and alternate delegates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate must receive written endorsement from the constituent association representing the jurisdiction within which the medical student's educational program is located, in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.3.3 Representatives to the Business Meeting.

7.3.3.1 Representatives. The AMA medical student members of each educational program as defined in Bylaw 1.1.1 may select one representative and one alternate representative. An educational program as defined in Bylaw 1.1.1 that has a total student population (excluding students at associated administrative campuses) greater than 999 may select one additional representative and one additional alternate representative.

7.3.3.2 Medical School Separate Campus. The AMA medical student members of an educational program as defined in Bylaw 1.1.1 that has more than one campus may select a representative and an alternate representative from each campus. A separate campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the medical student body are assigned for some portion of their instruction over a period of time not less than an academic year. The Governing Council shall establish appropriate rules, subject to approval of the Board of Trustees, for credentialing all representatives.

7.3.3.3 National Medical Specialty Societies, Federal Services, and Professional Interest Medical Associations. Each national medical specialty society, Federal Service, and professional interest medical association granted representation in the House of Delegates that has established a medical student component is entitled to one representative and one alternate representative selected by the medical student members of the organization. The Governing Council shall adopt uniform rules and criteria to determine if an organization represented in the House of Delegates has established a medical student membership component so as to qualify for representation at the Business Meeting. The procedure by which the medical student representative from the organization is selected must meet the requirements established by the Governing Council.

7.3.3.4 National Medical Student Organizations. National medical student organizations that have been granted representation in the Medical Student Section Business Meeting may select one representative and one alternate representative.

7.3.3.4.1 Criteria for Eligibility. National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting:

- a. The organization must be national in scope.
- b. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in Bylaw 1.1.1.
- c. Membership in the organization must be available to all medical students, without discrimination.

d. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.

e. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

7.3.3.4.2 Procedure. The Medical Student Section shall adopt appropriate rules for the application, acceptance and retention of national medical student organizations. Recommendations for acceptance and discontinuance shall be subject to the approval of the Board of Trustees.

7.3.3.4.3 Rights and Responsibilities. The medical student representative of each national medical student organization granted representation in the Business Meeting shall have full voting rights, including the right to vote in any elections at the conclusion of a 2-year probationary period with regular attendance. The representatives shall not be eligible for election to any office in the Medical Student Section.

7.3.3.5 Other Groups. The Association of American Medical Colleges – Organization of Student Representatives and the American Association of Colleges of Osteopathic Medicine – Council of Osteopathic Student Government Presidents are each entitled to one representative and one alternate representative selected by the medical student members of the organization. The procedure by which the medical student representative from each of these groups is selected must meet the requirements established by the Governing Council.

7.3.3.6 Certification. All representatives to the Business Meeting must be medical student members of the AMA and shall be properly certified to the Governing Council in accordance with rules established by the Governing Council.

7.3.4 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.6.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the AMA.

7.3.4.2 To adopt procedures for election of Medical Student Regional delegates and alternate delegates established in Bylaw 2.3.

7.3.4.3 To elect Medical Student Regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the AMA. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618
(A-22)

Introduced by: Oklahoma

Subject: Extending the Delegate Apportionment Freeze During COVID-19 Pandemic

Referred to: Reference Committee F

1 Whereas, The COVID-19 pandemic has been difficult for physicians and the practice of
2 medicine; many physicians have elected not to renew their memberships in organized medicine
3 due to numerous reasons; and
4

5 Whereas, 40% of the Oklahoma State Medical Association active dues paying members in 2021
6 and 36% in 2022 took a self-determined 50% dues reduction for the COVID-19 hardship; and
7

8 Whereas, Because of the COVID-19 pandemic, many state and specialty associations have not
9 been able to meet in person to utilize their usual platforms to promote the importance of
10 organized medicine; and
11

12 Whereas, At the November 2020 Special Meeting, the House of Delegates asked that our AMA
13 extend the current grace period from one year to two years for losing a delegate from a state
14 medical or national medical specialty society until the end of 2022; and
15

16 Whereas, The “freeze” adopted at November 2020 meeting proved to benefit 22 states,
17 Alabama, Arkansas, California, Colorado, District of Columbia, Florida, Hawaii, Illinois, Kansas,
18 Massachusetts, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania,
19 Rhode Island, South Carolina, South Dakota, Virginia, and Washington(1); and
20

21 Whereas, The current freeze has left the overall size of the House of Delegates unchanged and
22 will seat 693 delegates during 2022(2); and
23

24 Whereas, Many states and specialty societies have continued to have decreased AMA
25 membership; therefore be it
26

27 RESOLVED, That our American Medical Association extend the current delegate apportionment
28 freeze for losing a delegate from a state medical or specialty society until the end of 2023.
29 (Directive to Take Action)

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

Received: 05/11/22

References

1. <https://www.maq.org/wp-content/uploads/2021/05/2021-Delegate-Apportionment-States.pdf>
2. <https://www.ama-assn.org/system/files/2022-delegate-apportionment-memos.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 619
(A-22)

Introduced by: Texas, South Carolina, Florida, Mississippi, New Jersey, Pennsylvania

Subject: Focus and Priority for the AMA House of Delegates

Referred to: Reference Committee F

1 Whereas, The speakers of the American Medical Association House of Delegates established a
2 Resolutions Committee for the 2021 Special Meeting; and
3

4 Whereas, The Resolutions Committee will streamline and increase the efficiency of the
5 business of the house; and
6

7 Whereas, Resolution 605, Nov. 21, was referred to the Board of Trustees for study with a verbal
8 request for a report back at the 2022 Annual Meeting, and no report has been issued; and
9

10 Whereas, The number of resolutions submitted to our AMA continues to remain very high; and
11

12 Whereas, Our AMA needs to prioritize and focus to develop policy and act on the issues that
13 are pertinent and important to practicing physicians; that require urgent attention; on which our
14 AMA is the appropriate organization to lead; on which an AMA stance would have a positive
15 impact; that have not been considered previously and voted down; or about which good AMA
16 policy does not already exist; therefore be it
17

18 RESOLVED, That the Resolutions Committee be formed as a standing committee of the house,
19 the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the
20 annual and interim meetings of the AMA House of Delegates (Directive to Take Action); and be
21 it further
22

23 RESOLVED, That the membership of the Resolutions Committee be composed of one Medical
24 Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one
25 Young Physicians Section (YPS) member, all appointed by the speakers through nominations of
26 the MSS, RFS, and YPS respectively; six regional members appointed by the speakers through
27 nominations from the regional caucuses; six specialty members appointed by the speakers
28 through nominations from the specialty caucuses; three section members appointed by the
29 speakers through nominations from sections other than the MSS, RFS, and YPS; and one past
30 president appointed by the speakers (Directive to Take Action); and be it further
31

32 RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms
33 except for the past president and the MSS and RFS members, who shall serve a one-year term
34 (Directive to Take Action); and be it further
35

36 RESOLVED, That members of the Resolutions Committee cannot serve more than four years
37 consecutively (Directive to Take Action); and be it further

1 RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or
2 her term, the speakers will replace that member with someone from a similar member group in
3 consultation with that group the next year, and the new member will complete the unfulfilled
4 term (Directive to Take Action); and be it further

5
6 RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions
7 using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of
8 physicians affected), urgency (the urgency of the resolution and the impact of not acting),
9 appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy
10 (whether an AMA stance would have a positive impact), history (whether the resolution has
11 been submitted previously and not accepted), and existing policy (whether an AMA policy
12 already effectively covers the issue). Resolutions would not have to meet all of these
13 parameters nor would these parameters have to be considered equally (Directive to Take
14 Action); and be it further

15
16 RESOLVED, That the composite (or average) score of all members of the Resolutions
17 Committee be used to numerically rank the proposed resolutions. No resolution with a
18 composite average score of less than 2 would be recommended for consideration. The
19 Resolutions Committee would further determine the cutoff score above which resolutions would
20 be considered by the house based on the available time for reference committee and house
21 discussion, and the list of resolutions ranked available for consideration would be titled
22 “Resolutions Recommended to be Heard by the HOD” (Directive to Take Action); and be it
23 further

24
25 RESOLVED, That the Resolutions Committee also make recommendations on all resolutions
26 submitted recommending reaffirmation of established AMA policy and create a list titled
27 “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for
28 acceptance (Directive to Take Action); and be it further

29
30 RESOLVED, That the membership of the Resolutions Committee be published on the AMA
31 website with a notice that the appointed members should not be contacted, lobbied, or coerced;
32 any such activity must be reported to the AMA Grievance Committee for investigation; and
33 should the alleged violations be valid, disciplinary action of the offending person will follow
34 (Directive to Take Action); and be it further

35
36 RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing
37 Committee with the defined charge, composition, and functions as defined above for all AMA
38 HOD meetings effective Interim 2022. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000 assuming the resolution committee would not convene in person.

Received: 05/09/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 620
(A-22)

Introduced by: Ohio

Subject: Review of Health Insurance Companies and Their Subsidiaries' Business Practices

Referred to: Reference Committee F

1 Whereas, In 2021 a jury awarded \$60 million in punitive damages to three Nevada-based
2 TeamHealth affiliates in their case against United Healthcare for unfair payment and
3 reimbursement tactics; and
4

5 Whereas, In 2008, Ingenix, a subsidiary of United Healthcare, reached a settlement of \$400
6 million due to knowingly using falsified data in order to cause physicians to be underpaid for
7 their services; and
8

9 Whereas, Our AMA was instrumental in exposing the 2008 fraudulent activity; therefore be it
10

11 RESOLVED, That our American Medical Association conduct a review of the business practices
12 of health insurance companies in order to identify potential fraudulent and unfair activities.
13 (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$300K annually.

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 723
(A-22)

Introduced by: American Medical Women's Association

Subject: Physician Burnout

Referred to: Reference Committee G

1 Whereas, Burnout was an issue for physicians, especially women, prior to the pandemic; and

2
3 Whereas, The reported rates of physician burnout have increased significantly to over 60%
4 since the start of the pandemic; and

5
6 Whereas, Physicians, especially women, are leaving the workforce due to professional and
7 personal stressors and burnout that have exacerbated during the pandemic; and

8
9 Whereas, Burnout can lead to mental health conditions, such as depression and anxiety; and

10
11 Whereas, Hospital credentialing applications and renewals typically include questions about
12 specific mental or physical health conditions and related treatments; and

13
14 Whereas, Physicians are reluctant to seek mental health care due to concerns about the impact
15 of that on their ability to gain or maintain hospital credentialing; and

16
17 Whereas, The Joint Commission accredits over 20,000 organizations and programs in the
18 United States; and

19
20 Whereas, The goals of The Joint Commission and the Centers for Medicare and Medicaid
21 Services are to set standards that improve care through assuring patient and staff safety; and

22
23 Whereas, Physician reluctance to seek care can impact their wellbeing and that of their patients;
24 be it therefore

25
26 RESOLVED, That our American Medical Association work with the Centers for Medicare and
27 Medicaid Services and The Joint Commission to assure that clinician, including physician,
28 wellbeing is a component of standards for hospital certification (Directive to Take Action); and
29 be it further

30
31 RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of
32 focus on clinician wellbeing, to include the removal of intrusive questions regarding clinician
33 physical or mental health or related treatments on initial or renewal hospital credentialing
34 applications. (Directive to Take Action)

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

Received: 05/09/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 724
(A-22)

Introduced by: Texas

Subject: Ensuring Medical Practice Viability Through Reallocation of Insurance
Savings During the COVID-19 Pandemic

Referred to: Reference Committee G

1 Whereas, The impact of COVID-19 has been evident in primary care physician and specialist
2 offices throughout the nation; and
3

4 Whereas, Government shutdowns and mandates have decreased the patient volume seen in
5 physicians' offices as well as the volume of elective procedures (including inpatient and
6 outpatient surgeries); and
7

8 Whereas, In areas with a large proportion of Medicaid patients, the volume of patients needed
9 to maintain practice viability could be as much as three times more than that in other areas; and
10

11 Whereas, Daily patient volume has remained low throughout the pandemic; and
12

13 Whereas, Currently uncompensated physician workload in this pandemic has increased
14 because patient panel responsibility has remained unchanged; and
15

16 Whereas, Federal, state, and commercial payers function primarily as fee-for-service; and
17

18 Whereas, Uniformly decreased patient visits (services) across the nation leads to increased
19 savings (revenue) for federal, state, and commercial payers; therefore be it
20

21 RESOVLED, That our American Medical Association continue to advocate for and educate
22 members about practice viability issues (Directive to Take Action); and
23

24 RESOLVED, That our AMA work with private payers to encourage them to pass along savings
25 generated during the pandemic to patients (Directive to Take Action); and
26

27 RESOLVED, That our AMA advocate that all plans follow medical loss ratio requirements and,
28 as appropriate and with particular mindfulness of the public health emergency, issue rebates to
29 patients (Directive to Take Action); and
30

31 RESOLVED, That our AMA urge health plans to offer practices per-patient-per-month fees for
32 innovative practice models to improve practice sustainability. (Directive to Take Action)

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

Received: 05/09/22

RELEVANT AMA POLICY

Insurance Industry Antitrust Exemption H-180.975

It is the policy of the AMA (1) to continue efforts to have the insurance industry be more responsive to the concerns of physicians, including collective negotiations with physicians and their representatives regarding delivery of medical care;

(2) to continue efforts to have the insurance industry be more responsive to the concerns of physicians and their representatives regarding reasonable requests for appropriate information and data;

(3) to analyze proposed amendments to the McCarran-Ferguson Act to determine whether they will increase physicians' ability to deal with insurance companies, or increase appropriate scrutiny of insurance industry practices by the courts; and

(4) to continue to monitor closely and support appropriate legislation to accomplish the above objectives.

Citation: BOT Rep. DD, I-91; Reaffirmed: Res. 213, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 725
(A-22)

Introduced by: Texas

Subject: Compensation to Physicians for Authorizations and Preauthorizations

Referred to: Reference Committee G

1 Whereas, Insurance and managed care companies ("payers") demand authorization and
2 preauthorization for coverage and for payment of prescriptions, laboratory tests, radiology tests,
3 procedures, surgeries, hospitalizations, and physician visits; and
4

5 Whereas, Other professionals, such as attorneys and accountants, bill and get paid for time
6 spent personally and by their staff in providing services; and
7

8 Whereas, The effect of such authorization and preauthorization is to delay and deny care, thus
9 allowing payers to save, keep, and invest money that otherwise would provide patient care; and
10

11 Whereas, Such authorization and preauthorization procedures cause unnecessary testing and
12 delay of care, which may harm patients; and
13

14 Whereas, The overwhelming majority of such authorization and preauthorization requests
15 eventually are authorized by payers; and
16

17 Whereas, Physicians and their staff spend onerous amounts of time and money on
18 authorization and preauthorization procedures, thus increasing physician overhead while
19 decreasing availability for patient care by physicians and their staff; and
20

21 Whereas, Authorization and preauthorization procedures and their direct and indirect costs
22 endanger the viability of private medical practices; and
23

24 Whereas, Physicians are not compensated for such authorization and preauthorization
25 procedures, which benefit payers to the detriment of patients and physicians; therefore be it
26

27 RESOLVED, That the American Medical Association support legislation that requires insurance
28 and managed care companies, including companies managing governmental insurance plans
29 ("payers"), to compensate physicians for the time physicians and their staff spend on
30 authorization and preauthorization procedures. Such legislation is recommended to include the
31 following: Compensation shall be paid in full by payers to physicians without deductible,
32 coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such
33 processes imposed by payers. Physicians shall bill payers for time spent by physicians and their
34 staff in performing such tasks at a rate commensurate with that of the most highly trained
35 professionals. Payers shall pay physicians promptly upon receiving such a bill with significant
36 interest penalties assessed for delay in payment. Billable services for authorization and
37 preauthorization include, but are not limited to, time spent filling out forms, making telephone
38 calls (including time spent negotiating phone trees and hold time), documenting in the patient's
39 medical record, communicating with the patient, altering treatment plans (such as changing
40 medications to comply with formularies), printing, copying, and faxing. (Directive to Take Action)

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

Received: 05/09/22

RELEVANT AMA POLICY

Payer Measures for Private and Public Health Insurance D-180.984

Our AMA will work with state medical associations, employer coalitions, physician billing services, and other appropriate groups to evaluate on an annual basis and recommend standards for "payer measures" for the insurance industry and government payers to be publicly reported for consumers that may include information such as:

1. Number of patients enrolled
2. Total company and individual plan revenue/expense and profit
3. Procedures covered and not covered by policy
4. Number of primary and specialist physicians
5. Number of denied claims (and %)
 - a. Number denied based on "pre-existing condition"
 - b. Number denied and later allowed
 - c. Number denied for no reason
6. Waiting time for authorization of common procedures
7. Waiting time for authorization of advanced procedures
8. Waiting time for payment
9. Morbidity and mortality due to denied or delayed care
10. Number of appeals by customers or physicians
11. Number of successful appeals by customers or physicians
12. Number of consumer complaints
13. Number of government fines/sanctions
14. Use of economic profiling of physicians to limit physicians on panel
15. Use of quality measures approved by qualified specialty societies

Citation: Res. 703, I-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 828, I-08; Reaffirmed: CMS Rep. 01, A-18

Strengthening the Accountability of Health Care Reviewers D-185.977

Our AMA will continue to advocate that all health plans, including self-insured plans, be subject to state prior authorization reforms that align with AMA policy.

Citation: Res. 206, I-20

Managed Care H-285.998

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21

Prior Authorization Relief in Medicare Advantage Plans H-320.938

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
- f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
- g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
- h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
- i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Citation: Res. 814, I-18

Prior Authorization and Utilization Management Reform H-320.939

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.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: 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; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21

Abuse of Preauthorization Procedures H-320.945

Our AMA opposes the abuse of preauthorization by advocating the following positions:

- (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.
- (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial.

Citation: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

- (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require 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; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20

Processing Prior Authorization Decisions D-320.979

Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.

Citation: Res. 712, I-20

Require Payers to Share Prior Authorization Cost Burden D-320.980

Our AMA will petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.

Citation: Res. 811, I-19

Payer Accountability H-320.982

Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.

(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a

physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

Preauthorization D-320.988

1. Our AMA will conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (a) authorizations and preauthorizations and (b) denial of authorization appeals.
2. There will be a report back to the House of Delegates at the 2015 Annual Meeting
3. Our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.

Citation: Sub. Res. 215, I-14; Reaffirmed: CMS Rep. 07, A-16

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 726
(A-22)

Introduced by: Texas

Subject: Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs

Referred to: Reference Committee G

Whereas, In battling the opioid epidemic, payers have required that physicians spend time reviewing controlled substances prescription history for patients prior to prescribing such medications via state prescription monitoring programs (PMPs); and

Whereas, Many states require that physicians electronically prescribe controlled substances; and

Whereas, Electronic health record platforms charge physicians separately and additionally for controlled substances electronic prescriptions; and

Whereas, Because of these additional expenses of time and money imposed by the state PMP requirements, many physicians have chosen to not prescribe controlled substances, thus causing avoidable pain and suffering to patients; and

Whereas, Increasing expenses of time and money endanger the private practice of medicine; therefore it be

RESOLVED, That our American Medical Association advocate for appropriate physician payment through the resource-based relative value scale to cover the expense of technology required to electronically prescribe controlled substances (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for appropriate physician payment to cover the extra time and expense to query state prescription monitoring programs as required by law. (Directive to Take Action)

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

Received: 05/09/22

RELEVANT AMA POLICY

Electronic Prescribing D-120.972

1. Our AMA will (a) ask the Drug Enforcement Administration to accelerate the promulgation of digital certificate standards for direct electronic transmission of controlled substance prescriptions to support the patient safety goals and other governmental initiatives; and (b) urge Congress to work towards unifying state prescription standards and standard vocabularies to facilitate adoption of electronic prescribing.

2. Our AMA will support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

Citation: Res. 525, A-05; Reaffirmed in lieu of Res. 215, I-08; Reaffirmation A-09; Appended: Res. 237, A-18; Appended: Res. 250, A-18; Modified: BOT Rep. 20, A-19

Completing the Electronic Prescription Loop for Controlled Substances D-120.945

Our AMA will seek from the US Drug Enforcement Administration (DEA) and/or Centers for Medicare & Medicaid Services (CMS) a requirement that all pharmacies and Pharmacy Benefits Managers (PBMs) acquire and implement the appropriate electronic prescribing of controlled substances (EPCS) software application to accept electronically transmitted controlled substance prescriptions from any physician or hospital-based computer system that complies with CMS and DEA certification requirements on e-prescribing.

Citation: Res. 208, A-14; Reaffirmed: BOT Rep. 20, A-19

Federal Roadblocks to E-Prescribing D-120.958

1. Our AMA will: work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, brand medically necessary or the equivalent on a paper prescription form.

2. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-prescribing.

3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.

4. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.

5. Our AMA will work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances.

6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

7. Our AMA will work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs.

Citation: Res. 230, A-08; Reaffirmed in lieu of Res. 215, I-08; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 244, A-12; Appended: Res. 714, A-13; Appended: Res. 203, A-14; Modified: BOT Rep. 06, I-17; Reaffirmed: BOT Rep. 20, A-19

Safe and Efficient E-Prescribing H-120.921

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.

B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.

C. Implementation teams to prioritize the adoption of features like structured and codified Sig

formats that can help address quality issues, allowing for free text when necessary.

D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.

E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.

F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.

G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.

H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.

i. Organizational leadership to designate e-prescribing as the default prescription method.

J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.

K. States to allow integration of PDMP data into EHR systems.

L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.

M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Citation: BOT Rep. 20, A-19

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.

Citation: BOT Rep. 3, A-08; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16; Appended: BOT Rep. 13, A-17

Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs H-95.920

Our AMA: (1) will advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care; (2) urges EHR vendors and Health Information Exchanges (HIEs) to increase transparency of custom connections and costs for physicians to integrate their products in their practices; (3) supports state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring; (4) supports initiatives to improve the functionality of state PDMPs, including: (a) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (b) directing state-based PDMP’s to support improved integrated EHR interfaces; and (5) will advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider.

Citation: BOT Rep. 07, I-18; Appended: Res. 244, A-19

Support for Prescription Drug Monitoring Programs H-95.929

Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Citation: Res. 218, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 727
(A-22)

Introduced by: Texas

Subject: Utilization Review, Medical Necessity Determination, Prior Authorization
Decisions

Referred to: Reference Committee G

1 Whereas, Prior authorization requirements are increasing in number yearly, and this burden is
2 driving administrative costs to an estimated \$68,274 per physician per year, which equates to
3 \$31 billion annually, according to *Health Affairs*; and
4

5 Whereas, Prior authorizations delay care and create obstacles to patients receiving optimal
6 care. A recent American Medical Association survey reported 91% of physicians said prior
7 authorization had a significant or somewhat negative impact on their patients' clinical outcome,
8 and 28% said prior authorization intrusion led to a serious adverse event for a patient under
9 their care; and
10

11 Whereas, Decisions made by insurance medical directors, physicians conducting utilization
12 reviews, and physicians providing peer-to-peer reviews on behalf of insurance companies affect
13 patient care and can lead to adverse outcomes; therefore be it
14

15 RESOLVED, That the American Medical Association advocate for implementation of a federal
16 version of Texas' "gold card" law (House Bill 3459), which aims to curb onerous prior
17 authorization practices by many state-regulated health insurers and health maintenance
18 organizations (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA House of Delegates adopt a similar policy to Texas's "gold card" law
21 (House Bill 3459) (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA request that the Council on Ethical and Judicial Affairs devise
24 ethical opinions similar to the Texas Medical Association's Board of Councilors' opinions
25 regarding medical necessity determination and utilization review. (Directive to Take Action)

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

Received: 05/09/22

RELEVANT AMA POLICY

Utilization Review by Physicians H-320.973

1. It is the policy of the AMA to urge its constituent medical associations to (a) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (b) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.

2. Our AMA will continue to work with state medical associations to monitor utilization management policy

to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation.

Citation: Sub. Res. 175, A-90; Reaffirmation A-97; Reaffirmation A-06; Appended: CMS Rep. 1, I-14; Reaffirmation: A-18

Principles of Drug Utilization Review H-120.978

Our AMA adopts the following Principles of Drug Utilization Review.

Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.

Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.

Principle 5: Confidentiality of the relationship between patients and practitioners must be protected.

Characteristic: The DUR program must assure the security of its database.

Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.

Principle 7: The DUR program operations must be structured to achieve the principles of DUR.

Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.

Citation: (BOT Rep. PPP, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 6, A-03; Reaffirmed: CMS Rep. 4, A-13)

Medical Necessity and Utilization Review H-320.942

Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Citation: Res. 810, I-16; Reaffirmation: A-18