

Reference Committee D

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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

REPORT 15 OF THE BOARD OF TRUSTEES (A-22)
Addressing Public Health Disinformation
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. At the November 2021 special meeting of the AMA House of Delegates, the House adopted Policy D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals” which called on the AMA to study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue with a report back at the next meeting of the House of Delegates.

DISCUSSION. Disinformation is false or misleading information of which the author knows to be wrong and intends to cause harm. Health professionals are trusted messengers and the spread of disinformation by a few has implications for the entire profession. Physicians and health professionals have an ethical and professional responsibility to represent current scientific evidence accurately. The spread of health-related disinformation is unethical and unprofessional and harmful to patients and the public. Health professionals who participate in the media can offer effective and accessible medical perspectives, and they have an ethical obligation to consider how their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated.

During the COVID-19 pandemic, disinformation has been of the utmost concern, leading some to describe a secondary “infodemic,” wherein permanent harm may be done to the trust in institutions due to the sheer volume of mis- and disinformation spread in a rapidly changing and sensitive environment. Disinformation claims made by health professionals can be directly linked to topics such as the promotion of unproven COVID-19 treatments, false claims of vaccine side effects, and public health guidance that is not evidence-based.

This report discusses the impact of disinformation disseminated by health professional, provides an overview of the ways that disinformation is spread including through social media platform and traditional media, reviews the impact of peer-reviewed journals and preprints, and examines incentives for spreading disinformation. The report also provides an overview of the authority of health professional licensing and credentialing boards in addressing disinformation.

CONCLUSION. The dissemination of health-related disinformation by health professionals is a complex topic and one for which a comprehensive strategy will be necessary to protect patients and public health. Such a strategy is outlined in the Appendix of this report. The strategy addresses actions that can be taken by the AMA, by social medial companies, by publishers, state licensing bodies, credentialing boards, state and specialty health professional societies, by those who accredit continuing education to stop the spread of disinformation and protect the health of the public.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-22

Subject: Addressing Public Health Disinformation

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2

3 At the November 2021 special meeting of the AMA House of Delegates, the House adopted Policy
4 D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals”
5 which called on the AMA to study disinformation disseminated by health professionals and its
6 impact on public health and present a comprehensive strategy to address this issue with a report
7 back at the next meeting of the House of Delegates.

8

9 During the COVID-19 pandemic, the public health emergency was undoubtedly worsened and
10 prolonged due to disinformation campaigns sowing distrust in vaccines, pharmaceutical
11 interventions, and public health mitigation measures. Health professionals spreading disinformation
12 lends credibility to specious claims.

13

14 For the purposes of this report, health professionals include, but are not limited to, those working in
15 health care who maintain a professional license. Examples of licensed health care professionals
16 include, but are not limited to: Doctor of Medicine or Doctor of Osteopathic Medicine, nurses,
17 nurse practitioners, nurse-midwives, physician assistants, chiropractors, podiatrists, dentists,
18 optometrists, pharmacists, clinical psychologists and clinical social workers. Health professionals
19 may also include public health professionals, who may or may not be licensed health care
20 professionals.

21

22 OVERVIEW OF DISINFORMATION

23

24 For the purposes of this report, the term “disinformation” is used to describe false or misleading
25 information of which the author knows to be wrong and intends to cause harm.¹ Disinformation is
26 often interchangeably used with “misinformation”, however a key distinction between the two is
27 the intent of the author. Misinformation is spread unwittingly, whereas disinformation is
28 intentionally disseminated to confuse, deceive, or otherwise manipulate the reader. Misinformation
29 is outside of the scope of this report as is the spread of disinformation by non-health professionals.

30

31 *Example of Disinformation Campaigns*

32

33 During the COVID-19 pandemic, disinformation has been among the utmost concerns, leading
34 some to describe a secondary “infodemic” wherein permanent harm may be done to the trust in
35 institutions due to the sheer volume of disinformation spread in a rapidly changing and sensitive
36 environment.^{2,3,4} Disinformation claims made by health professionals can be directly linked to
37 topics such as the promotion of unproven COVID-19 treatments, false claims of vaccine side
38 effects, and public health guidance that is not evidence-based.^{5,6,7,8} Health professionals have been

1 involved in disseminating health-related disinformation, long before the COVID-19 pandemic, this
2 includes promoting vaccine skepticism^{9,10} and dangerous anti-cancer treatments.¹¹

3
4 An illustrative case study for how health professionals have spread disinformation is around
5 vaccinations. Vaccine hesitancy dates back to the 1700s and the practice of inoculation, particularly
6 when vaccination was accompanied by government action.¹² These debates have centered around
7 bodily autonomy and the role of the government in mandating immunizations. While the merits of
8 these questions are debated by policymakers, the arguments for vaccination must be based in
9 science. However, historically, this has not been the case, with numerous instances of health
10 professionals engaging in disinformation tactics to achieve their desired political outcomes.

11
12 For example, a 1974 study falsely claimed that 36 children developed neurological side effects
13 within 24 hours after receiving a routine diphtheria, tetanus, and pertussis (DTaP) vaccination.¹³
14 Despite efforts by public health officials to combat the false information, the bell had already been
15 rung, and many countries saw sharp declines in DTaP vaccine uptake, and some halted vaccination
16 campaigns altogether.

17
18 Then, in 1998, a manuscript was published in *The Lancet* using fabricated data linking the measles,
19 mumps, and rubella (MMR) vaccine to autism.¹⁴ While the physician responsible for the fraudulent
20 research ultimately had their medical license revoked and the paper was retracted, the impact it had
21 on vaccine discourse and uptake was profound. One study found that this single manuscript falsely
22 linking MMR vaccines to autism resulted in an immediate increase of about 70 MMR injury claims
23 per month to the Vaccine Adverse Events Reporting System (VAERS), and a 10 percent increase
24 in negative media coverage of vaccines.¹⁵ The false connection between autism and vaccines has
25 persisted and is often part of the core messaging in anti-vaccination campaigns.^{16,17,18}

26
27 The troubling impact of health professionals creating and spreading vaccine disinformation in the
28 context of the COVID-19 pandemic is discussed later within this report.

29 30 PROFESSIONAL RESPONSIBILITY OF HEALTH PROFESSIONALS

31 32 *Ethical Obligations*

33
34 Health professional associations have outlined standards of conduct that define ethical behavior.
35 The AMA Principles of Medical Ethics state that a physician should continue to apply scientific
36 knowledge and recognize the responsibility to participate in activities contributing to the
37 improvement of the community and the betterment of public health.¹⁹ Given the growing reliance
38 and presence of health information on the internet, the AMA has also published *Code of Medical*
39 *Ethics* Opinion 8.12, “Ethical Physician Conduct in the Media.” This opinion outlines that although
40 physicians who participate in the media can offer effective and accessible medical perspectives,
41 they have an ethical obligation to consider how their conduct can affect their medical colleagues,
42 other health care professionals, as well as institutions with which they are affiliated. Most
43 importantly, it states that physicians will be taken as authorities when they engage with the media
44 and therefore should ensure that the medical information, they provide is accurate and based on
45 valid scientific evidence. Further, *Code of Medical Ethics* Opinion 10.1 states that even when a
46 physician is in a role that does not involve directly providing care for patients in clinical settings,
47 “physicians are seen by patients and the public, as well as their colleagues and coworkers as
48 professionals who have committed themselves to the values and norms of medicine.”

49
50 Finally, it has been suggested that health professionals also have an ethical obligation to correct
51 false or misleading health information, share truthful health information, and direct people to

1 reliable sources of health information within their communities and spheres of influence.²⁰ In the
2 modern information age, where the unconstrained and largely unregulated proliferation of false
3 health information is enabled by the internet, health professionals have an ethical duty to actively
4 participate in conversations about health and help correct false or harmful information.

5
6 Other health professionals have similar ethical standards. For example, the Ohio State Chiropractic
7 Association Members' Code of Ethics states that chiropractors should act as members of a
8 profession dedicated to the promotion of health, the prevention of illness and the alleviation of
9 suffering. This includes guidance that chiropractors should exercise care when advertising to
10 ensure the information is accurate, truthful, not misleading, false or deceptive, and is accurate in
11 representing the chiropractor's professional status and area of special competence.²¹

12
13 Recently, the Boards of the American Pharmacists Association and the National Alliance of State
14 Pharmacy Associations approved principles that are essential to fulfill a pharmacist's professional
15 responsibilities. This includes using evidence-based guidelines when prescribing medications and
16 emphasizing that pharmacists play an active role in reinforcing consistent and reliable public health
17 messages while helping to provide accurate health-related information to patients in an era of
18 misinformation.²²

19 20 *Trust in Health Professionals*

21
22 It is critical to understand the role that health professionals acting in good faith play in the health
23 information ecosystem. Multiple surveys have shown that health professionals are the most trusted
24 sources of health information, particularly when compared to government institutions.^{23,24} Data
25 suggests that nine-in-ten U.S. adults (89 percent) have either a great deal or a fair amount of
26 confidence in medical scientists to act in the public interest.²⁵ In 2018, the top three professions in
27 the Gallup poll for honesty and ethics were nurses, medical doctors, and pharmacists.²⁶ Nurses
28 were rated the highest, where 84 percent of people rated nurses' honesty and ethical standards as
29 high or very high. Studies find that trust in health professionals lead to increased vaccination rates,
30 whereas mistrust of health professionals was found to be a common theme amongst parents who
31 lacked confidence in vaccines.^{27,28} While trust is a complex, multi-faceted concept, the professional
32 nature, high degree of training, and ability to connect to an individual are important factors for
33 health professionals gaining and maintaining trust.

34
35 It should also be noted that health professionals are more than just experts in the public square.
36 Many health professionals engage with the public as educators, advocates, entertainers and more. It
37 is critical that future measures against disinformation preserve the totality of roles that health
38 professionals may hold. Similarly, it must be respectful of the totality of thought that may exist
39 within the profession and hold spaces for professional discourse that may challenge traditional
40 thinking. While heterodoxy may undermine trust and allow for the spread of disinformation, it is
41 often a necessary step before learning from historical mistakes. Actions taken that strengthen trust
42 in health professionals will be undercut if they result in an overall retraction of health professionals
43 from the public square, which may result in less credible voices filling the void. Policies and
44 practices that promote the perception of inaction or indifference corrode trust similarly to bad
45 behavior.²⁹

1 IMPACT OF DISINFORMATION

2
3 *Impact on Patients and the Public*

4
5 The prevalence disinformation about COVID-19 has been fueled by social media. More than three
6 quarters of U.S. adults either believe or are not sure about at least one of eight false statements
7 about the COVID-19 pandemic or COVID-19 vaccines.³⁰ The same study found one-third believe
8 or are unsure whether deaths due to the COVID-19 vaccine are being intentionally hidden by the
9 government, and about three in ten each believe or are unsure whether COVID-19 vaccines have
10 been shown to cause infertility. In addition, between a fifth and a quarter of the public surveyed
11 believe or are unsure whether the vaccines can cause COVID-19 (25 percent), contain a microchip
12 (24 percent), or can change DNA (21 percent).

13
14 The spread of disinformation regarding unproven medications to treat COVID-19 also led to direct
15 patient harm. In the first eight months of 2021, the National Poison Data System reported an
16 increase of over 150 percent in the number of calls made to poison control centers, with states such
17 as Mississippi issuing alerts about the surge of calls from individuals overdosing on ivermectin.³¹

18
19 *Impact on Minoritized Communities*

20
21 When assessing the impact of disinformation spread by health professionals, it is also important to
22 consider the disproportionate impact that it may have on different communities. Many of the most
23 common COVID-19 disinformation campaigns require the reader to distrust institutions such as the
24 federal government or the pharmaceutical industry.³² For minoritized communities that have
25 historically been failed by these same institutions, the initial belief that those in power may be
26 untrustworthy is not as large of a logical leap.^{33,34} These beliefs may be intergenerational and are
27 reinforced by the multitude of injustices faced by minoritized communities in health care.^{35,36} As
28 such, any strategy for combating disinformation which does not center itself in restorative justice is
29 unlikely to strengthen trust in any meaningful and lasting way.

30
31 *Impact on the Health Profession*

32
33 Disinformation spread by health professionals can have both direct and indirect impacts on health
34 care and public health. In the above example of vaccine disinformation, health professionals
35 spreading falsified research resulted in decreases in vaccine confidence and uptake resulting in
36 outbreaks of preventable disease.³⁷ But it also corroded trust in health professionals which gave
37 way to targeted harassment campaigns of those following the science.³⁸

38
39 More difficult to measure are the indirect impacts. Studies have shown that an individual's trust in
40 their health professional directly correlates to more positive health outcomes, due to factors such as
41 more candid responses to personal questions and better adherence to treatment plans.³⁹ But when
42 health professionals engage in actively spreading disinformation, there may be an overall corrosion
43 of trust in health professionals.

44
45 *Economic Impact*

46
47 The spread of disinformation has had large economic impacts as seen during recent measles
48 outbreaks and the COVID-19 pandemic. Studies show that the cost of a measles outbreak ranges
49 from \$9,862 to \$1,063,936, with a median cost per case of \$32,805.⁴⁰ In 2013, the New York City
50 Department of Health and Mental Hygiene's response to a measles outbreak cost an estimated
51 \$395,000, which supported more than 10,000 hours of staff time along with other costs.⁴¹ In 2019,

1 Clark County Public Health, in Washington state, spent nearly \$865,000 responding to a measles
2 outbreak.⁴²

3
4 Data suggests that non-vaccination during the COVID-19 pandemic has caused harm of \$1 billion
5 per day and misinformation and disinformation has caused between 5 percent and 30 percent of this
6 harm.⁴⁶ Further, misinformation and disinformation has caused between \$50 and \$300 million
7 worth of total harm every day since May 2021.⁴⁶ These estimates demonstrate how mis- and
8 disinformation contributes to the spread of disease and the effect both can have on the public health
9 system. Finally, studies examining causality between mis- and disinformation and nonvaccination
10 are limited. One estimate suggests that of the 43 million people in the U.S. who have chosen
11 nonvaccination against COVID-19, 2 million to 12 million were unvaccinated because of
12 misinformation or disinformation.⁴³ More research is needed to better understand the impact of
13 disinformation on vaccination rates. Although the focus of this report is solely on disinformation,
14 the currently available data on the economic impact does not distinguish between the cost of
15 misinformation and disinformation.

16 17 HOW DISINFORMATION IS SPREAD

18 19 *Social Media*

20
21 It is impossible to discuss the spread of disinformation in modern times without mentioning social
22 media. While disinformation existed long before the internet and social media became
23 commonplace, it has acted as a multiplier of disinformation spread and a lightning rod for criticism.
24 Platforms such as Twitter, Facebook, YouTube, Instagram and TikTok have all faced recent
25 criticism over their handling of medical disinformation on their platforms.^{44,45,46} Even Doximity, a
26 platform targeted to credentialed physicians that does not allow anonymous users, has not been
27 immune to concerns over disinformation during the COVID-19 pandemic.⁴⁷

28
29 In the current environment, individuals often value convenience more than trust when making
30 decisions about their health. For example, when individuals were surveyed about consumer
31 behaviors regarding unregulated online pharmacies, approximately 1 in 4 Americans indicated that
32 they would accept higher risk from purchasing at an illegal, unregulated online pharmacy if it was
33 more convenient.⁴⁸ Alarming, prioritizing convenience over accuracy holds true for health
34 professionals. Paradoxically, one survey found that only 2.2 percent of health professionals found
35 social media to be a trustworthy source for health information, but 18.2 percent of the same cohort
36 indicated that they get health information from it.⁴⁹

37
38 Social media is a high-risk platform for receiving health information due to the main ways in which
39 users are shown content: algorithmic recommendations. Most social media platforms utilize
40 algorithms to promote content to the consumer in efforts to drive increased interaction with the site.
41 For example, YouTube estimates that approximately 70 percent of all videos watched on their
42 platform are through recommendations.⁵⁰ Researchers of social media platforms have shown that
43 algorithms tend to prioritize metrics such as watch time, likes and comments, all of which favors
44 content that elicits an emotional response like anger and reinforce previously held beliefs rather
45 than promote factual accuracy.⁵¹ For example, internal documents leaked from Facebook indicated
46 that their algorithm prioritized the “angry face” emoji reaction higher than the “thumbs up” (“like”)
47 reaction even when their own internal data suggested emotion-provoking content was more likely
48 to contain misinformation.⁵²

49
50 Amid intense criticism during the COVID-19 pandemic, some social media platforms began
51 adjusting their algorithms to de-incentivize disinformation or to automatically include cautionary

1 statements on high-risk content and provide links to trusted source such as the Centers for Disease
2 Control and Prevention (CDC) or World Health Organization.^{53,54,55, 56} Many of these policies are
3 too new to fully appreciate their impact, but preliminary studies suggest that tweaks to the
4 YouTube algorithm dropped views on videos supporting conspiracy theories by up to 70 percent.⁵⁷
5 It should be noted, however, that this effect may not be durable – that is, content creators learned
6 how to evade automated detection over time and the initial loss of views was partially recovered.

7
8 Social media companies at the end of the day are privately owned, profit-driven businesses. The
9 algorithms were designed to maximize advertising revenue and user retention. Broad, sudden
10 changes in policy that target disinformation may lead to an increase in competitors that market
11 themselves as bastions of free speech in the marketplace of ideas.

12
13 The ideal role of health professionals in the social media landscape is unlikely to be one solely
14 relying on reactive fact-checking. First, reactive fact-checking is unsustainable as it requires
15 significantly more effort to do the research and provide refutations than it does to create the
16 disinformation in the first place. Colloquially, this asymmetry of effort is referred to as
17 “Brandolini’s law”.⁵⁸ Second, by the time disinformation reaches a qualified health professional
18 who may be able to fact-check it, it is likely to have already had significant spread. Finally,
19 reactive fact-checking can result in the “Backfire effect,” in which some individuals are so invested
20 in maintaining their viewpoint that external attempts to correct disinformation will instead make
21 the reader *more* inclined to believe the disinformation.⁵⁹

22
23 As such, combating disinformation spread by health professionals, particularly over social media,
24 will require a three-pronged approach: deprioritizing disinformation in social media algorithms,
25 affirming and empowering the role of reactive fact-checking, and addressing any underlying
26 incentive structure for health professionals spreading health-related disinformation.

27 *Traditional Media and Paywalls*

28
29
30 When assessing the spread of health-related disinformation, it is important to understand where the
31 underlying data come from. Disinformation does not necessarily imply that claims are entirely
32 fabricated, but instead may rely on the distortion or intentional misrepresentation of otherwise valid
33 figures. In the medical research ecosystem, this is commonly seen with the misrepresentation of *in*
34 *vitro* results as holding significant value *in vivo*.

35
36 While the general public may not appreciate the nuance in medical research literature, health
37 professionals should, and risk spreading disinformation when they sensationalize research claims.
38 This is amplified further when health professionals are leaned on for their expertise in translating
39 complex topics by media organizations. Like social media companies discussed above, traditional
40 or online media companies often have the same financial motivations and accompanying tensions –
41 sensationalized stories result in increased readership while well-sourced, measured journalism is
42 expensive and time-consuming to create.^{60,61} Unfortunately this results in trustworthy news
43 increasingly being locked behind paywalls, with approximately 68 percent of U.S. news entities
44 limiting free access to their content in 2019, an increase of 13 percent over 2 years.⁶² As outlined
45 above, this creates an ecosystem for low-quality, sensationalist websites without journalistic
46 integrity to thrive due to the desire to value ease of access and convenience over perceived quality.

47
48 During the COVID-19 pandemic, some publications switched to a model in which public health
49 information was published for free. While this led to an increase in available high-quality
50 resources, it also required individuals to modify the routines they had built up over years of seeking
51 out free information, which may have limited impact.

1 *Peer-Reviewed Journals and Preprints*

2

3 Academic research faces a similar problem as social media and traditional print journalism:
4 convenient access trumps the perception of quality. During the COVID-19 pandemic, there has
5 been an unprecedented surge in the number of academic articles published as “preprints,” in which
6 research articles are disseminated prior to peer-review in an academic journal.⁶³

7

8 Under the traditional model, academic research is submitted to a journal, reviewed by an editor,
9 and then sent to experts in the field for anonymized peer review. These peer reviewers will
10 critically analyze the research for experimental structure and whether the conclusions offered are
11 supported by the collected data. Peer review may result in the researchers being required to
12 perform additional experiments to support their conclusions, or it may result in the research article
13 being rejected outright from the journal. It serves as a critical check in the scientific process to
14 enable high quality, trusted research, but it is often criticized as being unnecessarily slow and
15 needlessly antagonistic.⁶⁴

16

17 A preprint circumvents the peer review process by not being published in an academic journal and
18 instead being uploaded to a freely accessible database. This is not a new phenomenon, but the push
19 towards open access research and the appetite for up-to-date information during the COVID-19
20 public health emergency resulted in a surge in preprints, particularly in the life sciences. Preprints
21 have been praised as a way of elevating younger researchers, reducing predatory publishing in
22 which researchers may pay fees to less credible journals for favorable peer reviews, and generally
23 being more accepting of negative findings.⁶⁵

24

25 These benefits, however, require skipping peer review, meaning that the results may be less
26 trustworthy, particularly for non-expert audiences that may not be able to critically evaluate
27 experimental structures for things like adequate control groups. Depending on the author and the
28 database, preprints may be type-set to imitate the look of common academic journals, and most are
29 then assigned a Digital Object Identifier (DOI), which allows them to be tracked through academic
30 databases such as Crossref and Datacite. The name preprint suggests that the article is in the
31 process of undergoing peer review, but approximately 30 percent of life sciences preprints are
32 never published.⁶⁶

33

34 Preprints and paywalls represent a clear tension in solving the disinformation crisis. Access to an
35 individual, high-quality life sciences journal can cost thousands of dollars, and research is spread
36 across multiple journals in any given field. Yet free, easy-to-access preprints will often be the only
37 resource accessed by both health professionals and the public seeking to understand complex issues
38 even if they may be rife with errors, conflicts of interest or unsupported conclusions.

39

40 *Incentives for Spreading Disinformation*

41

42 Previous sections outlined why there is an audience for health disinformation content, but
43 spreading disinformation requires there to be a party engaging with malice. For health
44 professionals spreading health-related disinformation, this seems paradoxical. Most, if not all,
45 health professionals take a professional oath to do no harm, and a misinformed public would
46 seemingly make that job harder.

47

48 At first glance, health-related disinformation appears to be a highly fractured entity, as it is spread
49 through a huge number of social media accounts and micro-targeted blog sites. However, deeper
50 analysis reveals that the source of the various content is heavily centralized. For example, the

1 Center for Countering Digital Hate (CCDH) released a report in which they analyzed one month of
2 anti-vaccine posts on social media, and found that nearly two-thirds of the claims (over 812,000
3 individual posts) could be traced back to twelve individuals, nicknamed the “Disinformation
4 Dozen.”⁶⁷ This is in general agreement with the public statements of social media platforms such as
5 Doximity, which claim that less than one-tenth of one percent of their active users have been found
6 to spread disinformation.⁶⁸

7
8 Of the dozen individuals identified by CCDH, six have at one point held a license from a
9 professional medical accrediting body, and at least two others represent themselves as health
10 experts, albeit not from a credentialed profession. While it is impossible to infer intent from their
11 public statements, spreading disinformation is a lucrative business for the Disinformation Dozen.
12 The most common monetization model for health professionals spreading disinformation resembles
13 the “influencer economy” born out of social media: monetizing their video channels and social
14 media followings through advertisements, selling books containing medical disinformation,
15 running subscription-based services which procure and disseminate disinformation, multi-level
16 marketing schemes, public speaking tours, and paid media appearances.

17
18 Beyond the indirect routes of monetization, there are also instances of credentialed health
19 professionals using disinformation to drive patients towards their medical practices. For example,
20 one group currently under investigation by the House Select Subcommittee on the Coronavirus
21 Crisis is believed to be charging upwards of \$700 per patient for telehealth consults which were
22 advertised to be with health professionals more likely to prescribe controversial, medications not
23 authorized or approved to prevent or treat COVID-19.⁶⁹ The group is estimated to have generated
24 more than \$6.7 million in a 3-month period in 2021.

25
26 As such, any strategy to combat health professionals spreading disinformation must be two-fold: it
27 must address their ability to find an audience, and it must address their ability to monetize an
28 audience they do find.

29 30 AUTHORITY OF LICENSING AND CREDENTIALING BOARDS

31 32 *Authority of Licensing Boards*

33
34 Health professional boards exercise two main regulatory functions: licensure and discipline.⁷⁰
35 Licensure requires a demonstration of educational attainment and knowledge as evidence of
36 competence at the time when health professionals begin practicing. Discipline, in contrast, oversees
37 ongoing practice in a state. Health professionals can be disciplined for numerous misbehaviors,
38 from business offenses to problems in the quality of care. Disciplinary actions range in severity
39 from non-public warning letters, to public reprimand, to suspension or revocation of the license to
40 practice. Disciplinary action is intended to protect the public directly by removing problematic
41 health professionals from practice, restricting their scope of practice, or improving their practice.
42 Various state practice acts establish the boards’ mission, structure and power, and the
43 administrative procedure acts govern many health professional board processes, especially for
44 promulgating regulations and holding hearings. Legislation also provides boards with their budgets
45 and staffing authority. The structure and authority of medical boards vary from state to state.^{71,72,73}
46 Some boards are independent and maintain all licensing and disciplinary powers, while others are
47 part of a larger umbrella agency, such as a state department of health, exercising varied levels of
48 responsibilities or functioning in an advisory capacity.^{74,75} Despite the varying scope and authority
49 of boards, many health professional boards state that the use of a false, fraudulent, or deceptive
50 statements in any connection with their practice, is ground for discipline.

1 *Limitations to Board Authority*

2
3 Unfortunately, boards face various impediments to their disciplinary powers. These include low
4 funding and staffing, insufficient legal framework (i.e., too little statutory priority for public
5 protection, no explicit quality ground for discipline, high legal standards of proof),⁷⁶ high costs of
6 investigation and formal legal process, differing authority by state, and fear of litigation by
7 aggrieved health professionals. Medical boards have faced some criticism. Some have argued that
8 state medical boards have significant discretion over the investigative and disciplinary process in
9 responding to complaints. However, they have no proactive capacity to monitor physicians outside
10 of formal and cumbersome complaint processes, and during the investigative period, physicians
11 under scrutiny are free to continue to spread disinformation and abuse their medical credentials
12 without restraint.⁷⁷

13
14 *First Amendment Considerations*

15
16 The Federation of State Medical Boards (FSMB) has warned physicians that spreading
17 disinformation about the COVID-19 vaccine could lead to the suspension or revocation of their
18 medical license.⁷⁸ However, licensing boards are state actors and are subject to the First
19 Amendment and are therefore limited in their ability to penalize health professionals based on the
20 content of their speech. The First Amendment's protection of freedom of speech applies to all
21 branches of government, including state licensing boards.⁷⁹ Based on existing Supreme Court
22 precedent, courts are unlikely to look favorably on license revocations based on statements a health
23 professional makes in a non-clinical context, even when those statements would constitute
24 malpractice if they were made to a patient under care. This is because the board would have the
25 burden of establishing not only that the interests it seeks to promote are compelling, but also that
26 disciplinary action is the least restrictive means of achieving those goals.

27
28 In 2018 the Supreme Court elaborated on the First Amendment's application to laws restricting
29 professional speech in *National Institute of Family and Life Advocates (NIFLA) v. Becerra*.⁸⁰ In
30 that case, the Court struck down a California law that, required "crisis pregnancy centers" that held
31 licenses as health care facilities to notify women that the state provided free and low-cost
32 pregnancy-related services, including abortions. The Supreme Court concluded that laws regulating
33 professional speech are exempt from normal First Amendment standards. This suggested that the
34 First Amendment places few, if any, restrictions on regulations of professional conduct.

35
36 This case has important implications for the scope of licensing boards' disciplinary authority. It
37 implies that boards may have considerable discretion when disciplining health professionals for
38 statements made in connection with medical procedures, because these actions would constitute the
39 regulation of professional conduct. However, because a health professionals' statements on
40 platforms such as social media are unconnected with any medical procedure, disciplinary actions
41 based on those statements would be subject to normal First Amendment standards.

42
43 **ACTIONS TAKEN BY HEALTH PROFESSIONAL BOARDS**

44
45 *Federation of State Medical Boards*

46
47 The FSMB released a statement in response to a dramatic increase in the dissemination of COVID-
48 19 vaccine misinformation and disinformation by physicians and other health care professionals on
49 social media platforms, online, and in media. FSMB noted that the spread of mis- and
50 disinformation is grounds for disciplinary action by state medical boards, that could result in
51 suspension or revocation of their medical license.⁸³ Since the release of that statement at least 15

1 boards have published statements about licensees spreading false or misleading information, and at
2 least 12 boards have taken disciplinary action against a licensee for spreading false or misleading
3 information.⁸¹ The FSMB also released data from their 2021 annual survey which documented how
4 medical boards are being impacted by, and addressing, physicians and other health care
5 professionals who spread false or misleading information about COVID-19. The survey found that
6 67 percent of state medical boards have experienced an increase in complaints related to licensee
7 dissemination of false or misleading information, 26 percent have made or published statements
8 about the dissemination of false or misleading information, and 21 percent have taken a
9 disciplinary action against a licensee disseminating false or misleading information.⁸³

10
11 *American Board of Medical Specialties*

12
13 In 2021, the American Board of Medical Specialties (ABMS) released a statement stating that the
14 spread of misinformation is harmful to public health, is unethical and unprofessional, and may
15 threaten certification by an ABMS Member Board.⁸² Further, the American Board of Emergency
16 Medicine⁸³, the American Board of Pathology⁸⁴ and a joint statement by the American Boards of
17 Family Medicine, Internal Medicine and Pediatrics⁸⁵ have stated that health professionals who are
18 certified by specialty boards and spread disinformation place their certifications at risk.

19
20 *National Council of State Boards of Nursing*

21
22 The National Council of State Boards of Nursing alongside multiple nursing organizations has also
23 released a policy statement noting that the dissemination disinformation pertaining to COVID-19,
24 vaccines, and associated treatments through verbal or written methods including social media may
25 be disciplined by nursing boards and may place their license in jeopardy.⁸⁶

26
27 *Pharmacy Boards*

28
29 The American Pharmacists Association as well as various state boards have noted that
30 inappropriately prescribing or dispensing medications that are not approved to prevent or treat
31 COVID-19 could be considered unethical and unprofessional conduct and may violate board
32 rules.^{87,88,89,90}

33
34 **LEGISLATIVE EFFORTS SURROUNDING DISINFORMATION**

35
36 *Federal Efforts*

37
38 Various federal efforts have been taken to address disinformation. For example, the CDC has
39 published strategies for communicating accurate information about COVID-19 vaccines,
40 responding to gaps in information, and confronting misinformation with evidence-based messaging
41 from credible sources.⁹¹ The Surgeon General of the United States also published a report on
42 strategies to help slow the spread of health misinformation during the COVID-19 pandemic and
43 beyond. This includes strategies that major players can take including the government, health
44 organizations, and individuals to address misinformation.⁹² Building upon this report, the Surgeon
45 General is now collecting data from technology companies and personal experiences about
46 misinformation during the COVID-19 pandemic.⁹³ Further, Senator Chris Murphy (D-Conn.) and
47 Senator Ben Ray Lujan (D-N.M.) will introduce a bill promote public education on health care
48 through a new committee in HHS. The Promoting Public Health Information Act will create the
49 Public Health Information and Communications Advisory Committee, a group within HHS
50 specializing in public health, medicine, communications and national security.⁹⁴

1 *State Efforts*

2
3 Given the growing impact of disinformation on the COVID-19 pandemic, state legislators have
4 introduced bills to combat disinformation. For example, California’s AB 2098 (2022), would
5 codify that licensed physicians disseminating or promoting misinformation or disinformation
6 related to COVID-19 constitutes unprofessional conduct that should result in disciplinary actions
7 by the Medical Board of California or the Osteopathic Medical Board of California. However,
8 these efforts by states have been met with great resistance. For example, Tennessee’s medical
9 licensing board voted to remove a policy opposing coronavirus misinformation from its website.⁹⁵
10 At the time of writing, 14 states have proposed legislation to weaken medical regulatory boards
11 authority and their ability to discipline doctors who spread false information or treat patients based
12 on it.⁹⁶ In response, the FSMB has released a statement in opposition to a growing legislative trend
13 aimed at limiting state medical boards’ ability to investigate complaints of patient harm.⁹⁷

14
15 **AMA POLICY AND ACTIONS TO ADDRESS DISINFORMATION**

16
17 *Existing AMA Policy*

18
19 AMA Policy D-440.914, “Addressing Public Health Disinformation Disseminated by Health
20 Professionals,” calls on the AMA to collaborate with relevant health professional societies and
21 other stakeholders: (a) on efforts to combat public health disinformation disseminated by health
22 professionals in all forms of media and (b) to address disinformation that undermines public health
23 initiatives; and (2) study disinformation disseminated by health professionals and its impact on
24 public health and present a comprehensive strategy to address this issue. Existing Policy
25 D-440.915, “Medical and Public Health Misinformation in the Age of Social Media,” encourages
26 social media companies to further strengthen their content moderation policies related to medical
27 and public health misinformation, including, but not limited to enhanced content monitoring,
28 augmentation of recommendation engines focused on false information, and stronger integration of
29 verified health information; (2) encourages social media companies to recognize the spread of
30 medical and public health misinformation over dissemination networks and collaborate with
31 relevant stakeholders to address this problem as appropriate, including but not limited to altering
32 underlying network dynamics or redesigning platform algorithms. The policy further calls on the
33 AMA to continue to support the dissemination of accurate medical and public health information
34 by public health organizations and health policy experts and work with public health agencies in an
35 effort to establish relationships with journalists and news agencies to enhance the public reach in
36 disseminating accurate medical and public health information.

37
38 Policy H-460.978, “Communication Among the Research Community, the Media and the Public,”
39 calls for increased cooperation between the scientific community and the media to improve the
40 reporting of biomedical research findings and to enhance the quality of health care information that
41 is disseminated to the public. The policy notes that both scientists and journalists should
42 communicate biomedical research findings accurately and in an appropriate context. Journalists
43 should include information on the limitations of research and should be cognizant of the emotional
44 content of the health news they report. Furthermore, academic institutions, private industry,
45 individual scientists, and funding agencies should not publicly announce results of biomedical
46 research unless they have received critical review by others in the scientific community.

47
48 *The AMA as a Public Trust*

49
50 Disinformation spread by health professionals is not a new phenomenon. In 1906, the AMA
51 formed the Propaganda Department (later renamed the Bureau of Investigation and subsequently

1 the Department of Investigation) to combat unscrupulous medical claims, often by those with
2 professional credentials.^{98, 99} While the public’s trust in many institutions has waned during the
3 COVID-19 pandemic, people still trust their doctors and doctors trust the AMA. In his November
4 12, 2021, address to the AMA House of Delegates, Dr. Madara noted that, “[t]he AMA exists to
5 benefit the public, but we do so in a very particular way—by being the physicians’ powerful ally in
6 patient care. We serve the public by serving those who care for the public. Supporting physicians
7 and improving our nation’s health has been our focus since 1847.”¹⁰⁰

8
9 Following the onset of the pandemic and the growing negative effect of disinformation on public
10 health initiatives to combat COVID-19 the HOD adopted Policy D-440.921, “An Urgent Initiative
11 to Support COVID-19 Vaccination and Information Programs,” which provided that that AMA
12 would institute a program to promote the integrity of a COVID-19 vaccination information by
13 educating the public about up-to-date, evidence-based information regarding COVID-19 and
14 counter misinformation by building public confidence, as well as educating physicians and other
15 healthcare professionals on means to disseminate accurate information and methods to combat
16 medical misinformation online. This directive informed the AMA’s active participation in the
17 COVID Collaborative in partnership with the Ad Council.

18
19 The AMA has also continued to issue press statements, noting the harm of mis- and disinformation
20 on the pandemic, has urged the CEOs of six leading social media and e-commerce companies to
21 assist the effort by combatting misinformation and disinformation about the vaccine on their
22 platforms, and sign on to joint statements addressing mis- and disinformation in prescribing
23 treatments for COVID-19. The AMA has remained a source of trusted information with the
24 COVID-19 resource center which provides physicians with up-to-date information about COVID-
25 19 news, research, vaccines and therapeutics.

26
27 *Council on Ethical and Judicial Affairs and AMA membership*

28
29 Further, the AMA’s Council on Ethical and Judicial Affairs (CEJA) has two primary
30 responsibilities. Through its policy development function, it maintains and updates the *AMA Code*
31 *of Medical Ethics*, and through its judicial function, it promotes adherence to the Code’s
32 professional ethical standards. CEJA has continued to publish *Code of Medical Ethics* opinions
33 considering the ethical role of physicians in media as well as in non-clinical settings. CEJA also
34 has the authority to expel or deny membership to the AMA, if the physician has been disciplined
35 by their state board and based upon the egregiousness of the physician’s conduct.

36
37 CONCLUSION

38
39 During the COVID-19 pandemic, disinformation has been of the utmost concern, leading some to
40 describe a secondary “infodemic,” wherein permanent harm may be done to the trust in institutions
41 due to the sheer volume of mis- and disinformation spread in a rapidly changing and sensitive
42 environment. Disinformation claims made by health professionals can be directly linked to topics
43 such as the promotion of unproven COVID-19 treatments, false claims of vaccine side effects, and
44 public health guidance that is not evidence-based.

45
46 Physicians and health professionals have an ethical and professional responsibility to represent
47 current scientific evidence accurately. The spread of health-related disinformation is unethical and
48 unprofessional and harmful to patients and the public. Health professionals who participate in the
49 media can offer effective and accessible medical perspectives, and they have an ethical obligation
50 to consider how their conduct can affect their medical colleagues, other health care professionals,

1 as well as institutions with which they are affiliated. Health professionals are trusted messengers
2 and the spread of disinformation by a few has implications for the entire profession.

3
4 Social media platforms are a known source of disinformation and have been under such intense
5 scrutiny recently that they may be amenable to reforms to bolster their credibility. Individual health
6 professionals tend to be good at fact-checking things they encounter, but by the time something has
7 gone viral, it is far too late. Health information should be treated differently and should be pre-
8 emptively screened prior to it going viral. Health information is rarely so urgent that preventing it
9 from going viral will impact a social media's audience and/or ability to stay socially relevant.
10 Disinformation spreads because it is profitable to do so. Cutting off access to a potential customer
11 base should be of the utmost importance as it is also clear that those who spread disinformation are
12 benefitting from it financially.

13
14 Preprints and paywalls represent a clear tension in solving the disinformation crisis. Access to an
15 individual, high-quality life sciences journal can cost thousands of dollars, and research is spread
16 across multiple journals in any given field. Yet free, easy-to-access preprints will often be the only
17 resource accessed by both health professionals and the public seeking to understand complex issues
18 even if they may be rife with errors, conflicts of interest or unsupported conclusions. Best practices
19 around paywalls and preprints to improve access to evidence-based information and analysis are
20 needed.

21
22 The dissemination of health-related disinformation by health professionals is a complex topic and
23 one for which a comprehensive strategy will be necessary to protect patients and public health.
24 Such a strategy is outlined in the Appendix. The strategy addresses actions that can be taken by the
25 AMA, by social medial companies, by publishers, state licensing bodies, credentialing boards, state
26 and specialty health professional societies, by those who accredit continuing education to stop the
27 spread of disinformation and protect the health of the public.

28 29 RECOMMENDATIONS

30
31 The Board of Trustees recommends that the following be adopted, and the remainder of this report
32 be filed.

- 33
34 1. That Policy D-440.914, "Addressing Public Health Disinformation Disseminated by Health
35 Professionals," be amended by addition and deletion to read as follows:
36 Our AMA will: (1) collaborate with relevant health professional societies and other
37 stakeholders: (a) on efforts to combat public health disinformation disseminated by health
38 professionals in all forms of media, ~~and~~ (b) ~~to~~ address disinformation that undermines public
39 health initiatives ~~by~~, and (c) implement a comprehensive strategy to address health-related
40 disinformation disseminated by health professionals that includes:
41 (1) Maintaining AMA as a trusted source of evidence-based information for physicians and
42 patients.
43 (2) Ensuring that evidence-based medical and public health information is accessible by
44 engaging with publishers, research institutions and media organizations to develop best
45 practices around paywalls and preprints to improve access to evidence-based information and
46 analysis.
47 (3) Addressing disinformation disseminated by health professionals via social media platforms
48 and addressing the monetization of spreading disinformation on social media platforms.
49 (4) Educating health professionals and the public on how to recognize disinformation as well
50 as how it spreads.

- 1 (5) Considering the role of health professional societies in serving as appropriate fact-checking
2 entities for health-related information disseminated by various media platforms.
3 (6) Encouraging continuing education to be available for health professionals who serve as
4 fact-checker to help prevent the dissemination of health-related disinformation.
5 (7) Ensuring licensing boards have the authority to take disciplinary action against health
6 professionals for spreading health-related disinformation and affirms that all speech in which a
7 health professional is utilizing their credentials is professional conduct and can be scrutinized
8 by their licensing entity.
9 (8) Ensuring specialty boards have the authority to take action against board certification for
10 health professionals spreading health-related disinformation.
11 (9) Encouraging state and local medical societies to engage in dispelling disinformation in
12 their jurisdictions.
13 ~~;~~ and (2) study disinformation disseminated by health professionals and its impact on public
14 health and present a comprehensive strategy to address this issue with a report back at the next
15 meeting of the House of Delegates. (Modify Current HOD Policy)
16
17 2. That Policies D-440.914, “Addressing Public Health Disinformation Disseminated by
18 Health Professionals,” “D-440.915, “Medical and Public Health Misinformation in the Age
19 of Social Media,” and H-460.978, “Communication Among the Research Community, the
20 Media and the Public” be reaffirmed (Reaffirm HOD Policy).

Fiscal Note: \$100,000

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APPENDIX

Comprehensive Strategy Against Medical & Public Health Disinformation

Goal	Objectives/Tactics
<p>Maintain AMA as a trusted source of evidence-based information for physicians and patients.</p>	<ul style="list-style-type: none"> • Provide evidence-based information to physicians. • Undertake public campaigns (like the COVID Collaborative on vaccines) in areas where disinformation is causing patients harm. • Educate health professionals and the public on how to recognize disinformation as well as how it spreads. • Continue to use the AMA’s voice to speak out against the spread of health-related disinformation being spread by health professionals. • Maintain that CEJA has the authority to revoke AMA membership for those physicians spreading health-related disinformation.
<p>Ensure that evidence-based information is accessible.</p>	<ul style="list-style-type: none"> • Engage with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis. • Discourage the dissemination of results of biomedical research unless they have received critical review by others in the scientific community.
<p>Address disinformation disseminated by health professionals via social media platforms.</p>	<ul style="list-style-type: none"> • Encourage health professionals’ usage of social media platforms with robust disinformation policies in place. • Encourage social media platforms to automatically flag health information for de-prioritization in the sharing algorithm (and/or temporarily disabling the “Share” functionality on websites like Facebook) until it has been affirmatively checked by an appropriate fact-checking entity • Consider the role of health professional societies in serving as appropriate fact-checking entities.
<p>Address the monetization of spreading disinformation on social media platforms.</p>	<ul style="list-style-type: none"> • Affirm that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity. This includes public appearances, social media posts, books, online videos, etc. • Health professionals should be responsible for representations of their professional recommendations in publications. • Upon license renewal, health professionals should be required to disclose all activities in which they have profited from their credential, including activities in which their credential lends credibility as an expert.

<p>Ensure licensing boards have the authority to take disciplinary action against health professionals spreading health-related disinformation.</p>	<ul style="list-style-type: none"> • Advocate for licensing boards to have authority to discipline health professionals spreading health-related disinformation. • Encourage increased transparency regarding the types of complaints referred for investigation, the current status of complaints in the investigation process, and what level of action is taken as a result of investigations. • Expedite timelines to process complaints in the domain of public health disinformation during public health emergencies.
<p>Offer continuing education for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.</p>	<ul style="list-style-type: none"> • Encourage appropriate accrediting bodies to provide health professionals with continuing education credit (or equivalent accreditation maintenance) for engaging with fact-checking organizations. This could be similar to current CME policies which allows health professionals to get credit for peer-reviewing literature. • Encourage trainings to be developed and offered to health professionals on how to address disinformation in ways that account for patients' diverse needs, concerns, backgrounds, and experiences.
<p>Ensure medical specialty boards have the authority to revoke the certification of health professionals for spreading health-related disinformation.</p>	<ul style="list-style-type: none"> • Support the authority of medical specialty boards in taking action against certification due to a diplomate engaging in unethical and unprofessional behavior by spreading disinformation that is harmful to public health. • Encourages medical specialty boards to work with social media platforms to verify and elevate credible sources of health information.
<p>Encourage state and local medical societies, and their equivalents for other health professional organizations, to engage in dispelling health-related disinformation in their jurisdictions.</p>	<ul style="list-style-type: none"> • Partner with community groups and other local organizations to prevent and address health disinformation.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-22

Subject: Council on Science and Public Health Sunset Review of 2012 House Policies

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

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

1 RECOMMENDATION

2

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

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-100.971	Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation	Our AMA will: (1) work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies (REMS) as a means to improve patient safety; and (2) work with the e-prescribing and point of care resource industries to increase physician awareness of REMS as a means to improve patient safety by including current Risk Evaluation and Mitigation Strategy information in their products. (Res. 521, A-12)	Retain; still relevant.
D-115.990	Prescription Container Labeling	1. Our AMA will work with relevant organizations to improve prescription labeling for visually or otherwise impaired patients and to increase awareness of available resources. 2. Our AMA will encourage state Boards of Pharmacy to adopt the newly revised standards contained in the United States Pharmacopeia general chapter on prescription container labeling, which offers specific guidance on how prescription labels should be organized in a patient-centered manner. (Res. 914, I-08; Appended: Res. 904, I-12)	Retain as amended. USP standards were last updated in 2020.
D-120.950	Use of Atypical Antipsychotics in Pediatric Patients	Our AMA will: (1) urge the National Institute of Mental Health to assist in developing guidance for physicians on the use of atypical antipsychotic drugs in pediatric patients; and (2) encourage and support ongoing federally funded research, with a focus on long term efficacy and safety studies, on the use of antipsychotic medication in the pediatric population. (CSAPH Rep. 1, I-12)	Retain, still relevant.
D-130.974	Emergency Preparedness	Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland	Retain; as amended to reference the Departments of Homeland Security and Health and Human Services and other appropriate federal agencies rather than specifying all relevant agencies within these two departments.

		<p>Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency.</p> <p>(Sub. Res. 803, I-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12)</p>	
D-135.977	Synthetic Gasification	<p>Our AMA supports will encourage the study of the health effects of clean coal technologies including synthetic gasification plants.</p> <p>(Res. 514, A-12)</p>	Retain as amended and change to H-policy.
D-425.992	Recommendations by the USPSTF	<p>Our AMA will express concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans and will encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study.</p> <p>(Res. 517, A-12)</p>	<p>Rescind, accomplished.</p> <p>These screenings are also addressed by Policy H-525.993, "Screening Mammography," and Policy H-425.980, "Screening and Early Detection of Prostate Cancer."</p> <p>Existing policy also addresses physician engagement in expert panels (See. H-410.955 and H-410.967 included below).</p>
D-440.938	Triclosan Antimicrobials	<p>Our AMA will encourage the Food and Drug Administration to finalize the triclosan antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use and will encourage the education of members on the issue of the importance of proper hand hygiene and the preferential use of plain soap and water or alcohol-based hand sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention.</p> <p>(Res. 513, A-12)</p>	Rescind. The FDA has issued a final rule (82 FR 60474) and established in 21 CFR 310 that Triclosan among other ingredients are not recognized as safe and effective,

D-440.999	Chemical Analysis Report of Public and Commercial Water	Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content, including fluoride, of commercially bottled water, as well as of the water supplies of cities or towns; (2) urges the FDA to require that annual water quality reports from bottled water manufacturers be publicly accessible in a readily available format; and (3) urges the FDA to evaluate bottled water for changes in quality after typical storage conditions. (Res. 427, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 3, A-12)	Retain; still relevant.
D-470.993	Government to Support Community Exercise Venues	Our AMA will encourages: (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)	Retain as amended and change to an H policy.
D-480.977	Medical Device "Use Before Dates"	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)	Retain, still relevant.
D-95.978	Public Service Announcements to Educate Children and Adults to Never to Use Medications Prescribed to Other Individuals	Our AMA will encourages interested stakeholders, federal agencies and pharmaceutical companies to develop public service announcements for television and other media to educate children and adults about the dangers of taking medications that are prescribed for others. (Res. 910, I-12)	Retain as amended and change to an H policy.
H-100.961	The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)	Our AMA urges that: (1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) require sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; (c) clearly specify that sponsors must assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available; and (d) conduct a long-term assessment of the prescribing patterns of drugs with REMS requirements.	Retain as amended to delete duplicate language.

		<p>(2) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.</p> <p>(3) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.</p> <p>(4) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.</p> <p>(5) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend that sponsors assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available.</p> <p>(6) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior.</p> <p>(7) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.</p> <p>(8) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.</p> <p>(9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent</p>	
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		<p>forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.</p> <p>(407) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced.</p> <p>(CSAPH Rep. 8, A-10; Reaffirmed: Res. 917, I-10; Appended: CSAPH Rep. 3, I-12)</p>	
H-120.950	Change DEA Procedures in Partial Filling of Schedule II Prescriptions	<p>Our AMA supports changes to requests that the federal Drug Enforcement Administration's change its partial filling of Schedule II Prescription regulation (21 CFR 1306.13) so that patients can acquire the balance of a prescription if, for whatever reason, only a portion of the supply was dispensed when the prescription was presented to a licensed pharmacy.</p> <p>(Res. 505, A-02; Reaffirmed: CSAPH Rep. 1, A-12)</p>	<p>Retain in part as amended.</p> <p>The Comprehensive Addiction and Recovery Act of 2016 created new partial dispensing exceptions which were incorporated into the DEA pharmacist's manual in 2020.</p>
H-120.973	DEA, Diagnosis and ICD-910-CM Codes on Prescriptions	<p>Our AMA, in order to protect patient confidentiality and to minimize administrative burdens on physicians, opposes requirements by pharmacies, prescription services, and insurance plans to include such information as ICD-910-CM codes and diagnoses on prescriptions.</p> <p>(Sub. Res. 518, A-93; Reaffirmation A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed: Res. 523, A-00; Amended: Res. 527, A-02; Modified: CSAPH Rep. 1, A-12)</p>	<p>Retain as amended with change in title.</p>
H-135.932	Light Pollution: Adverse Health Effects of Nighttime Lighting	<p>Our AMA:</p> <ol style="list-style-type: none"> 1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency. 2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment. 3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night. 4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. <p>(CSAPH Rep. 4, A-12)</p>	<p>Retain, still relevant.</p>

H-135.937	<p>Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings</p>	<p>Our AMA: (1) will advocate that all future outdoor lighting be of energy efficient designs to reduce waste of energy and production of greenhouse gasses that result from this wasted energy use; (2) supports light pollution reduction efforts and glare reduction efforts at both the national and state levels; and (3) supports efforts to ensure all future streetlights be of a fully shielded design or similar non-glare design to improve the safety of our roadways for all, but especially vision impaired and older drivers.</p> <p>(Res. 516, A-09; Reaffirmed: CSAPH Rep. 4, A-12)</p>	<p>Retain, as amended still relevant.</p>
H-135.959	<p>Eliminating Lead, Mercury and Benzene from Common Household Products</p>	<p>Our AMA: (1) supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products; (2) encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities; and (3) will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other health care professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices; (4) encourages efforts to minimize or eliminate lead in all commercial and household products.</p> <p>(Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03; Modified: CSAPH Rep. 7, A-10; Reaffirmed in lieu of Res. 522, A-12)</p>	<p>Retain; still relevant.</p>
H-140.855	<p>Gene Patents and Accessibility of Gene Testing</p>	<p>Our AMA: (1) opposes patents on naturally-occurring human DNA or RNA sequences; (2) supports legislation requiring that existing gene patents be broadly licensed so as not to limit access through exclusivity terms, excessive royalties or other unreasonable terms; and (3) supports legislation that would exempt from claims of infringement those who use patented genes for medical diagnosis and research.</p> <p>(Res. 526, A-10; Modified in lieu of Res. 504, A-12)</p>	<p>Retain; still relevant.</p>
H-150.935	<p>Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility</p>	<p>Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals.</p>	<p>Retain; still relevant.</p>

		(Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)	
H-170.961	Prevention of Obesity Through Instruction in Public Schools	Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)	Retain; still relevant.
H-170.999	Health Instruction and Physical Education in Schools	The AMA reaffirms its long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums, and encourages state and local medical societies to work with the appropriate health education officers and agencies in their communities to achieve this end. (BOT Res., A-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-245.968	Guidelines on Neonatal Resuscitation	Our AMA will support programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (Sub. Res. 520, A-12)	Retain; still relevant.
H-250.988	Low Cost Drugs to Poor <u>Economically Disadvantaged</u> Countries During Times of Pandemic Health Crises	Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor <u>economically disadvantaged</u> countries in an effort to improve public health and national stability. (Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain as amended with change in title. The term “economically disadvantaged” is preferred over “poor.”
H-410.955	Physician Representation on Expert Panels	Our AMA encourages government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those diseases. (Res. 509, A-10; Reaffirmation A-12; Reaffirmed: Sub. Res. 517, A-12)	Retain; still relevant.
H-410.960	Quality Patient Care Measures	Our AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice. (Res. 811, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; still relevant.

<p>H-410.967</p>	<p>Guide to Clinical Preventive Services</p>	<p>The AMA: (1) recommends the USPSTF guidelines Guide to Clinical Preventive Services to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations The Guide should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines.</p> <p>(CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12)</p>	<p>Retain as amended with change in title.</p> <p>The terminology “Guide to Clinical Preventive Services” is no longer utilized.</p>
<p>H-420.960</p>	<p>Effects of Work on Pregnancy</p>	<p>Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children; (2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age; (3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people women; (4) encourages employers to accommodate women's increased physical requirements of pregnant people during pregnancy; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and (5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.</p> <p>(CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12)</p>	<p>Retain as amended to include gender-neutral language.</p>
<p>H-430.994</p>	<p>Prison-Based Treatment Programs for Drug Abuse</p>	<p>Our AMA: (1) encourages the increased application to the prison setting of the principles, precepts and processes derived from drug-free residential therapeutic community experience; and (2) urges state health departments or other appropriate agencies to take the lead in working</p>	<p>Rescind. Outdated policy.</p> <p>See Policy H-430.987, “Medications for</p>

		with correction and substance abuse agencies for the expansion of such prison-based drug-free treatment programs. (Sub. Res. 124, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmation: I-12)	Opioid Use Disorder in Correctional Facilities”
H-430.997	Standards of Care for Inmates of Correctional Facilities	Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder 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)	Retain as amended to reflect clinically accurate language.
H-440.844	Expansion of National Diabetes Prevention Program	Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. (Sub. Res. 911, I-12)	Retain; still relevant.
H-440.848	Reimbursement for Influenza Vaccine	Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations. (CSAPH Rep. 5, I-12)	Retain; still relevant.
H-440.849	Adult Immunization	Our AMA (1) supports the development of a strong adult and adolescent immunization program in the United States; (2) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (3) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (4) encourages the National Vaccine <u>Adult and Influenza Vaccine</u> Immunization Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician; (5) promotes use of available public and professional educational materials to increase use	Retain as amended to reflect the appropriate name of the Summit.

		<p>of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; and (6) encourages third party payers to provide coverage for adult immunizations.</p> <p>(CSAPH Rep. 5, I-12)</p>	
H-440.852	Smallpox: A Scientific Update	<p>Our AMA will remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on smallpox vaccination and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States and develop appropriate recommendations as necessary.</p> <p>(CSA Rep. 2, I-02; BOT Action in response to referred for decision Recommendation 2 of CSA Rep. 2, I-02; Modified: CCB/CLRPD Rep. 4, A-12)</p>	Retain; still relevant.
H-440.872	HPV Vaccine and Cervical Cancer Prevention Worldwide	<p>1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.</p> <p>2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.</p> <p>3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.</p> <p>(Res. 503, A-07; Appended: Res. 6, A-12)</p>	Retain; still relevant.
H-440.889	Smallpox: A Scientific Update	<p>Our AMA strongly supports the June 20, 2002, Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data.</p> <p>(CSA Rep. 2, I-02; Reaffirmed: CSAPH Rep. 1, A-12)</p>	Retain with amendments; ACIP recommendations have been updated.

H-440.921	Pneumococcal Vaccination	<p>Our AMA encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations, for those at increased risk of serious pneumococcal infection and for all persons age 65 and over.</p> <p>(Res. 512, A-94; Reaffirmed: Res. 515. I-01; Reaffirmed: Res. 520, A-02; Modified: CSAPH Rep. 1, A-12)</p>	Retain with amendment should ACIP recommendations evolve based on the evidence.
H-445.995	Responses to News Reports and Articles	<p>Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues.</p> <p>(Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07; Reaffirmed: Res. 601, A-12)</p>	Retain; still relevant.
H-460.905	Clinical Application of Next Generation Genomic Sequencing	<ol style="list-style-type: none"> 1. Our AMA recognizes the utility of next-generation sequencing (NGS)-based technologies as tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes. 2. Our AMA encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests. 3. Our AMA will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies. 4. Our AMA will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate. 5. Our AMA will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process. <p>(CSAPH Rep. 4, I-12)</p>	Retain; still relevant.
H-470.975	Mandatory Physical Education	<p>The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes.</p>	Retain; still relevant.

		(Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07; Modified: BOT Rep. 21, A-12)	
H-470.989	Physical Fitness and Physical Education	Our AMA: (1) urges school boards, administrators and parents to provide physical education programs during elementary, junior high and senior high years; and (2) stresses that these programs be conducted by qualified personnel, be designed to teach health habits and physical skills, and be designed to instill a desire in the student for physical fitness that will carry over into adult life. (CSA Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmation I-98; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-470.990	Promotion of Exercise Within Medicine and Society	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)	Retain; still relevant
H-470.996	School and College Physical Education	Our AMA encourages effective instruction in physical education for all students in our schools and colleges. (BOT Rep. I, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-480.958	Bioengineered (Genetically Engineered) Crops and Foods	(1) Our AMA recognizes the continuing validity of the three major conclusions contained in the 1987 National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a) There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.)	Retain; still relevant with acknowledgment by the Council that an updated report to review more recent data is warranted.

		<p>(2) That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant or animal, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new bioengineered crops and foods.</p> <p>(3) Our AMA believes that as of June 2012, there is no scientific justification for special labeling of bioengineered foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education.</p> <p>(4) Our AMA supports mandatory pre-market systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly.</p> <p>(5) Our AMA supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers.</p> <p>(6) Our AMA recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing</p>	
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		<p>research developments in food biotechnology.</p> <p>(7) Our AMA urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased information and research activities on bioengineered foods.</p> <p>(CSA Rep. 10, I-00; Modified: CSAPH Rep. 1, A-10; Modified: <u>CASSAPH</u> Rep. 2, A-12)</p>	
H-480.964	Alternative Medicine	<p>Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment.</p> <p>(CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02; Modified: CSAPH Rep. 1, A-12)</p>	Retain; still relevant.
H-485.998	Television Commercials Aimed at Childre	<p>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.</p> <p>(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)</p>	Retain; still relevant.
H-495.974	Tax Incentives and Films Depicting Tobacco	<p>Our AMA will urge that no tax incentives be given for any motion picture production that depicts any tobacco product or non-pharmaceutical nicotine delivery device or its use, associated paraphernalia, related trademarks or promotional material, unless the film depicts the tobacco use of historical persons or unambiguously portrays the dire health consequences of tobacco use.</p> <p>(Res. 417, A-12)</p>	Retain; still relevant.
H-495.981	Light and Low-Tar Cigarettes	<p>Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine:</p> <p>(a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years.</p> <p>(b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-</p>	Retain; still relevant.

		<p>measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand.</p> <p>(d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers.</p> <p>(e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting.</p> <p>(f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands.</p> <p>(g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation.</p> <p>(h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette.</p> <p>Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products.</p> <p>(CSA Rep. 3, A-04; Reaffirmed in lieu of Res. 421, A-12)</p>	
<p>H-515.959</p>	<p>Reduction of Online Bullying</p>	<p>Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.</p> <p>(Res. 401, A-12)</p>	<p>Retain; still relevant</p>
<p>H-525.984</p>	<p>Breast Implants</p>	<p>Our AMA: (1) supports that individuals women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.</p>	<p>Retain as amended; to include gender-neutral language.</p>

		(CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12)	
H-55.974	Study of Cancer Incidence in 9/11 Responders	Our AMA will encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence. (Res. 501, A-12)	Retain; still relevant.
H-60.927	Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations	Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. (Res. 402, A-12)	Retain; still relevant
H-60.943	Bullying Behaviors Among Children and Adolescents	Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim; (2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents; (3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community	Retain; still relevant

		<p>programs and services for victims and perpetrators of bullying and other forms of violence and aggression;</p> <p>(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;</p> <p>(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and</p> <p>(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.</p> <p>(CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12)</p>	
<p>H-60.991</p>	<p>Providing Medical Services through School-Based Health Programs</p>	<p>(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school</p>	<p>Retain; still relevant.</p>

		<p>and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.</p> <p>(CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)</p>	
H-65.973	Health Care Disparities in Same-Sex Partner Households	<p>Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.</p> <p>(CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12)</p>	Retain; still relevant.
H-85.961	Accuracy, Importance, and Application of	<p>Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and</p>	Retain; still relevant.

	Data from the US Vital Statistics System	infant, as this information is the basis for the health and medical information on birth certificates. (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12)	
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REPORT 02 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-22)
Transformation of Rural Community Public Health Systems
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. More than 65 million people living in the United States reside in rural jurisdictions. Rural populations tend to be older, poorer, have less access to health care, have riskier health behaviors, and worse health outcomes than their urban counterparts. Data from the Centers for Disease Control and Prevention (CDC) demonstrates that people living in rural areas are more likely to die from five leading causes of death (heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke) than their urban counterparts. However, the challenges faced by rural areas are not uniform as they have their own unique cultural and geographic differences that benefit from leadership at the local level.

METHODS. English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to January 2022 using the search terms: “rural public health,” “rural community health,” and “rural health. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, applicable professional organizations, and foundations were also reviewed for relevant information.

DISCUSSION. There are more than 2400 local health departments (LHDs) in the United States. It is estimated that about half of LHDs are rural and they differ from their urban and suburban counterparts. Rural LHDs are often limited by budgets, staffing, and capacity constraints in providing public health services, thereby limiting their ability to respond to national public health and health care policy initiatives. With less funding and fewer staff, rural LHDs are often not able to meet the needs of a sicker population over a larger geographical area. It should be noted that some rural areas are not served by a LHD, but rather by a regional or state health department (e.g., Rhode Island). The lack of health care available in rural jurisdictions also contributes in part to the lack of essential and foundational public health services provided in rural communities with rural health departments often left to fill the gap in the absence of other sources of health care.

CONCLUSIONS. Ultimately, residents in rural communities should have equitable access to the essential and foundational public health services provided by the public health system in other jurisdictions. To achieve this, research is needed to determine the needs and models for delivering public health services in rural communities as well as best practices for addressing health behaviors and the social determinants of health in these communities. While examples of using telehealth during the COVID-19 pandemic and cross jurisdictional sharing are helpful, there is little in the published literature regarding successful models for increasing population level public health activities in rural communities. This is likely in part due to rural health departments having little capacity and funding to participate in research and publish results.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-22

Subject: Transformation of Rural Community Public Health Systems

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

1 INTRODUCTION

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3 Policy H-465.994, “Improving Rural Health,” asks that our American Medical Association study
4 efforts to optimize rural public health.

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6 BACKGROUND

7

8 More than 65 million people living in the United States reside in rural jurisdictions.¹ Rural
9 populations tend to be older, poorer, have less access to health care, have riskier health behaviors,
10 and worse health outcomes than their urban counterparts.^{2,3} Data from the Centers for Disease
11 Control and Prevention (CDC) demonstrate that people living in rural areas are more likely to die
12 from five leading causes of death (heart disease, cancer, unintentional injuries, chronic lower
13 respiratory disease, and stroke) than their urban counterparts.³ However, the challenges faced by
14 rural areas are not uniform as they have their own unique cultural and geographic differences that
15 benefit from leadership at the local level.

16

17 The Council’s N-21 report, “Full Commitment by our AMA to the Betterment and Strengthening
18 of Public Health Systems,” is highly relevant to this report. That report identified eight major gaps
19 or challenges in the U.S. public health infrastructure. While those challenges were not specific to
20 rural public health, they are broadly applicable across the governmental public health enterprise.
21 These include: (1) the lack of understanding and appreciation for public health; (2) the lack of
22 consistent, sustainable public health funding; (3) legal authority and politicization of public health;
23 (4) the governmental public health workforce; (5) the lack of data and surveillance and
24 interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the
25 lack of collaboration between medicine and public health; and (8) the gaps in the public health
26 infrastructure which contribute to the increasing inequities we see in health outcomes. This report
27 recognizes that these challenges are applicable to rural public health, but this report seeks to build
28 on those findings to examine the challenges and opportunities specific to rural public health.

29

30 Furthermore, issues related to rural health care have recently been studied by other AMA councils
31 and will not be the focus of this report. Report 3 of the Council on Medical Education, “Rural
32 Health Physician Workforce Disparities” was adopted as amended by the House of Delegates in
33 November of 2021. The report recognized the need for a multifaceted approach to address the gap
34 of rural health services and noted that the AMA continues to work to help identify ways to
35 encourage and incentivize qualified physicians to practice in our nation’s underserved areas,
36 including strategies to increase rural students’ exposure to careers in medicine to help expand rural
37 physician pathways. Report 9 of the Council on Medical Services, “Addressing Payment and
38 Delivery in Rural Hospitals” was adopted as amended by the House of Delegates in June of 2021.

1 The report notes that addressing payment issues for rural hospitals will help give those hospitals the
2 flexibility to offer more complex services. In turn, those services will boost financial viability,
3 allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access
4 to care. Policies resulting from these reports are noted below in the section on existing AMA
5 policy.

6
7 There are numerous definitions of “rural.” The definition of rural public health practice varies by
8 study. Given the limited research available on rural public health, the Council was broadly
9 inclusive of various definitions of rural, including the Census Bureau and the Office of
10 Management and Budget definitions, in reviewing the literature for this report.

11 12 METHODS

13
14 English language reports were selected from searches of the PubMed, Google Scholar, and
15 Cochrane Library databases from January 2012 to January 2022 using the search terms: “rural
16 public health,” “rural community health,” and “rural health.” Additional articles were identified by
17 manual review of the reference lists of pertinent publications. Websites managed by federal
18 agencies, applicable professional organizations, and foundations were also reviewed for relevant
19 information.

20 21 DISCUSSION

22 23 *Rural-Urban Disparities*

24
25 Residents of rural communities tend to be sicker, poorer, and have worse health behaviors (e.g.,
26 higher alcohol and tobacco use, physical inactivity) than their urban peers. According to the Center
27 for Rural Health Research, “the greatest challenge facing rural America is the confluence of four
28 social vectors: poverty, educational underachievement, poor health behaviors, and lack of access to
29 health care.”⁴ These four factors have produced “an intergenerational cycle” resulting in widening
30 gaps between rural America and the rest of the country.⁴

31
32 While urban public health systems have enhanced their scope of activities and organizational
33 networks since 2014, rural systems have lost capacity, suggesting system improvement initiatives
34 have had uneven success.⁵ While urban areas have seen significant improvements in some health
35 indicators, rural areas continue to lag, widening rural-urban health disparities. For example, from
36 2007 to 2017, rural-urban mortality disparities increased for 5 of 7 major causes of death tracked
37 by Healthy People 2020: coronary heart disease, cancer, diabetes, chronic obstructive pulmonary
38 disease, and suicide.⁶

39
40 These disparities have also been evident during the COVID-19 pandemic. In September 2020,
41 COVID-19 incidence (cases per 100,000 population) in rural counties surpassed that in urban
42 counties.⁷ When the CDC analyzed county-level vaccine administration data among adults aged 18
43 and older who received their first dose of either the Pfizer-BioNTech or Moderna COVID-19
44 vaccine, or a single dose of the Janssen COVID-19 vaccine from December 14, 2020–April 10,
45 2021. They found that adult COVID-19 vaccination coverage was lower in rural counties (38.9
46 percent) than in urban counties (45.7 percent) overall.⁷ Though it is suggested that implementing
47 approaches tailored to local community needs, partnering with local community-based
48 organizations and faith leaders, and engaging with underserved populations directly and through
49 partners has helped increase vaccination rates in some rural communities.⁷

1 In describing disparities between rural and urban communities, there is a focus on the lack of
 2 resources and resulting impact on health of those living in rural communities, but it is important to
 3 highlight that the lack of resources has stimulated creativity and often brings people together across
 4 sectors in rural communities to solve the problems facing their population.⁸ Researchers working
 5 in rural communities describe “cross-sector engagement facilitated by strong social cohesion and a
 6 willingness to roll up one’s sleeves to address challenges head on.”⁸ This “strong connectivity
 7 across sectors and actors” in rural areas, has resulted in organizations forming partnerships to
 8 address issues related to the economy, nutrition, health care, business, and education.⁹ Research
 9 also suggests that rural communities are resilient, defined as “the ability to prepare and plan for,
 10 absorb, recover from or more successfully adapt to actual or potential adverse events.” This
 11 resilience enables rural communities to respond to economic and social changes.⁹ Rural
 12 communities are also described as having “pride in place, a shared history, and a shared culture.”⁸

13 14 *Access to Health Care*

15
16 Access to health care in rural jurisdictions impacts the ability of the public health systems to focus
 17 on essential public health services and functions. Nearly 35 years ago, the Institute of Medicine’s
 18 report on the “Future of Public Health” noted that the responsibility for providing medical care to
 19 individuals has drained vital resources and attention away from disease prevention and health
 20 promotion efforts that benefit the entire community.¹⁰ While many health departments have moved
 21 away from providing clinical services, local health departments (LHDs) in rural areas are often left
 22 to fill the gaps in the absence of health care providers. If LHDs in these jurisdictions did stop
 23 providing clinical services, they would not be available for the general population. Rural LHDs
 24 play a critical role in meeting the needs of the residents by providing clinical preventive services,
 25 vaccinations, treatment, and maternal and child health services.¹¹ Rural LHDs also rely more on
 26 clinical services because they receive a higher proportion of revenue from clinical sources than
 27 their urban counterparts.¹²

28 29 HEALTH DEPARTMENT STRUCTURE AND FUNCTIONS

30
31 There are more than 2400 local health departments (LHDs) in the United States. It is estimated that
 32 about half of LHDs are rural and they differ from their urban and suburban counterparts.¹ Rural
 33 LHDs, similar to their urban counterparts, are often limited by budgets, staffing, and capacity
 34 constraints in providing public health services, thereby limiting their ability to respond to national
 35 public health and health care policy initiatives.¹³ With less funding and fewer staff, rural LHDs are
 36 often not able to meet the needs of a sicker population over a larger geographical area.¹⁴ It should
 37 be noted that some rural areas are not served by a LHD, but rather by a regional or state health
 38 department (e.g. Rhode Island).

39 40 *Leadership and Workforce*

41
42 Effective public health practice requires a well-prepared, multi-disciplinary workforce that is
 43 equipped to meet the needs of the community being served.¹⁵ The Public Health Accreditation
 44 Board standards call for the development of a “sufficient number of qualified public health
 45 workers” and a competent workforce through assessment of staff competencies, individual training
 46 and professional development, and a supportive work environment. Building a strong public health
 47 workforce pipeline was also identified as a need in Public Health 3.0 with a focus on leadership
 48 and management skills in systems thinking and coalition building¹⁶

49
50 More than 80 percent of LHD full-time employees (FTEs) (112,000) are employed in departments
 51 serving urban areas. Only 18 percent of LHD FTEs (24,000) are employed by LHDs that serve

1 rural populations.¹⁷ Small, rural LHDs often have fewer staff than their urban counterparts.¹ Nurses
2 are often the executive in jurisdictions with a population less than 50,000, while executives of
3 jurisdictions with more than 250,000 are predominantly physicians.¹⁸ Overall, small/rural health
4 departments employ fewer FTEs than do large/urban departments, resulting in a narrower range of
5 public health skills. Seventy-eight percent of LHD executives have no formal public health
6 training, while executives of larger jurisdictions are more likely to have a public health degree.¹⁸

7
8 The other challenge facing the public health workforce more broadly is a significant number of
9 governmental public health workers are planning to leave their position. Data from the Public
10 Health Workforce Interests and Needs Survey found that more than one-fifth of LHD staff intended
11 to leave their position in the next year for reasons other than retirement.¹⁹ Salary, lack of
12 opportunity for advancement, and workplace environment were the top three reasons for leaving.¹⁹

13 14 *Funding Sources*

15
16 The governmental public health system is inadequately funded. The CDC's core budget has been
17 essentially flat, which directly impacts funding for state and local public health across the
18 country.²⁰ Rural LHDs are more reliant on federal, state, and clinical revenues as compared to their
19 urban counterparts.^{1,17} The predictability and stability of public health financing poses a challenge
20 for rural LHDs.² Operating on grant dollars can make it difficult to be responsive to community
21 needs and to create new FTEs at the local level. Furthermore, transfers of governmental funding
22 from federal and state levels to rural LHDs is less common as compared to urban LHDs.¹ Local
23 funding for public health is also often based on the tax base, which is low and declining in many
24 rural areas making local investments in public health difficult.²¹ Without meaningful growth in the
25 resources available, it is challenging for local governments to meaningfully invest in public
26 programs.¹

27
28 As noted above, the difference in clinical revenues among rural and urban LHDs is notable, with a
29 mean of \$21 per capita for rural jurisdictions versus \$6 per capita for urban jurisdictions.¹⁷ LHDs
30 experienced decreases in clinical revenue between 2010 and 2016.² Urban LHDs provided fewer
31 primary care services in 2016; rural LHDs provided more mental health and substance use disorder
32 services.² Overall, rural LHDs generate more revenue from the Centers for Medicare and Medicaid
33 Services and clinical services than their urban counterparts.²

34 35 *Access to Data*

36
37 Limited availability or access to data, data quality issues, and limited staff with expertise in
38 informatics and data analysis can also contribute to disparities between rural and urban LHDs. One
39 of the biggest data challenges facing rural areas relates to privacy and confidentiality. While some
40 data sets are publicly available for a large urban area, they may not be publicly available for rural
41 areas due to the small size of the population and the possibility that an individual would be
42 identifiable based on their condition or other demographic data. Outdated data sets or the lack of
43 real-time data also makes it challenging to understand important local issues and made timely
44 decisions.

45 46 *Public Health Programs and Services*

47
48 The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect
49 and promote the health of all people in all communities.²² The Foundational Public Health Services
50 (FPHS) framework is thought of as the minimum level of programs and services that governmental
51 public health should be delivering in every jurisdiction. The FPHS framework allows for the

1 identification of capacity and resource gaps; determination of the cost for assuring foundational
2 activities; and justification of funding needs.²³ However, it is also recognized that to best serve
3 their communities, LHDs may provide additional services and require capacity in different areas.²³

4
5 Maintaining the capacity to provide the nationally recommended public health services in rural
6 areas can be challenging. Public health accreditation, which incorporates the EPHS and FPHS
7 frameworks within its standards, is seen as an important step to improve the quality and
8 effectiveness of public health services, but a shortage of funds, lack of staff, and insufficient staff
9 knowledge are major barriers for rural LHDs to achieve accreditation. The programs and services
10 provided by rural health departments differ from their urban peers. According to the National
11 Association of City and County Health Officials (NACCHO) Profile Survey, LHDs serving rural
12 jurisdictions are more likely to provide certain clinical services, including childhood and adult
13 immunizations, maternal and child health services, and screening/treatment for various
14 conditions.¹⁷ The result is inequities in public health services across jurisdictions.

15 16 *Rural Public Health Networks*

17
18 Unlike urban health departments, which are represented through the Big Cities Health Coalition,
19 there is no national group to which rural public health agencies belong and work collaboratively to
20 advocate on behalf of rural public health and build relationships among staff.¹ The lack of rural
21 public health-focused advocacy has resulted in a lack of focus on rural population health. National
22 public health advocacy organizations typically do not focus on population health needs among rural
23 populations, and national rural advocacy organizations have largely focused narrowly on health
24 care access. While there has been some focus on rural public health challenges, it tends to be issue-
25 specific, such as with the opioid epidemic.¹

26
27 Similarly, while there are federal agencies focused on rural health care, the focus on rural public
28 health is minimal. For example, the CDC does not have a centralized rural office. Rather, the
29 Office of the Associate Director for Policy and Strategy coordinates policy and programmatic
30 efforts across the agency on issues relevant to rural health.²⁴ In March of 2022, Congress approved
31 a revised version of the Consolidated Appropriations Act (H.R. 2417), which provides funding for
32 the remainder of FY22 and averted a government shutdown. The bill requests the CDC to assess
33 and submit a report within 180 days of enactment of the bill on the agency's rural-focused efforts
34 and strengthening such efforts.

35 36 RURAL PUBLIC HEALTH OPPORTUNITIES

37 38 *Cross Jurisdictional Sharing*

39
40 Cross-jurisdictional sharing (CJS) is a growing strategy used by health departments to address
41 opportunities and challenges such as tight budgets, increased burden of disease, and regional
42 planning needs.²⁵ By pooling resources, sharing staff, expertise, funds and programs across
43 jurisdictions, health departments can accomplish more than they could alone.²⁶ CJS can range from
44 as needed assistance such as sharing information or equipment to regionalization/consolidation,
45 such as merging existing LHDs.²⁶ The Center for Sharing Public Health Services has outlined
46 success factors, facilitating factors, and project characteristics (i.e. senior level support, effective
47 communication) that can increase the likelihood of successful CJS.²⁷

48
49 One example of successful CJS arrangements include is two rural upstate New York counties that
50 were struggling to provide public health leadership and services forming a relationship that
51 integrated select functions and services, including the sharing of a director and deputy director,

1 while maintaining two distinct LHDs.²⁸ The counties also contract together for medical and
2 environmental engineering consulting, share an early childhood transportation provider, and share
3 additional purchasing in some programs.²⁸ By sharing personnel and functions, management
4 personnel costs have been cut in half and both counties have saved over \$1 million for the counties
5 combined.²⁸ Challenges have included anxiety among existing staffers who were concerned that
6 their positions may be cut if tasks become shared or integrated. In New York, state legislation also
7 limits how far integration can go, which has limited some efficiencies.²⁸

8 9 *Telehealth*

10
11 Small, rural health departments have limited access to technology and to information that is
12 available primarily electronically. The inability to provide in-person services because of the
13 COVID-19 pandemic has forced rural LHDs to evaluate different modalities for providing public
14 health services.¹⁴ During the pandemic, rural LHDs used online meeting platforms to provide
15 smoking cessation, diabetes self-management, and other health education classes to multiple
16 counties. This provided a broader population with access to public health services. Telehealth can
17 also help mitigate the lack of transportation, which is a known barrier to care.¹⁴ Anecdotal evidence
18 suggests that technology has allowed LHDs to maintain and expand the reach and scope of the
19 services they provide.¹⁴ While the use of telehealth to improve access to public health services is
20 promising, and could improve health equity, many rural areas still lack high-speed broadband.²⁹

21 22 *Partnerships*

23
24 Models that stress collaboration among rural LHDs and community partners hold promise for
25 meeting the challenges of rural public health. Building partnerships among LHDs, community
26 health centers, healthcare organizations, academic medical centers, offices of rural health,
27 hospitals, non-profit organizations, and the private sector is essential to meet the needs of these
28 communities.³⁰ NACCHO has created a guide to share recommendations and stories from the field
29 about developing and maintaining partnerships in rural communities.³⁰

30 31 EXISTING AMA POLICY

32
33 The AMA has extensive policy addressing rural health and access to health care. Policies
34 addressing rural public health are limited to Policy H-465.994, “Improving Rural Health,” which
35 states that the AMA will “work with other organizations interested in public health to identify and
36 disseminate concrete examples of administrative leadership and funding structures that support and
37 optimize local, community-based rural public health; develop an advocacy plan to positively
38 impact local, community-based rural public health including but not limited to the development of
39 rural public health networks, training of current and future rural physicians in core public health
40 techniques and novel funding mechanisms to support public health initiatives that are led and
41 managed by local public health authorities.”

42
43 AMA Policy H-465.994, “Improving Rural Health,” also urges physicians practicing in rural areas
44 to be actively involved in efforts to develop and implement proposals for improving rural health
45 care. Policy H-465.997, “Access to and Quality of Rural Health Care,” states that the AMA
46 believes that solutions to access problems in rural areas should be developed through the efforts of
47 voluntary local health planning groups, coordinated at the regional or state level by a similar
48 voluntary health planning entity. The AMA also supports efforts to place National Health Service
49 Corps physicians in underserved areas of the country.

1 AMA Policy H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage”
2 calls on the AMA to encourage medical schools and residency programs to develop educationally
3 sound rural clinical preceptorships and rotations and develop educational strategies for alleviating
4 rural physician shortages. Policy D-465.997, “Rural Health Physician Workforce Disparities,” calls
5 on the AMA to monitor the status and outcomes of the 2020 Census to assess the impact of
6 physician supply and patient demand in rural communities.”
7

8 AMA Policy, D-465.998. “Addressing Payment and Delivery in Rural Hospitals” calls on the
9 AMA to advocate that public and private payers take the following actions to ensure payment to
10 rural hospitals is adequate and appropriate: create a capacity payment to support the minimum
11 fixed costs of essential services, including surge capacity, regardless of volume; provide adequate
12 service-based payments to cover the costs of services delivered in small communities; adequately
13 compensate physicians for standby and on-call time to enable very small rural hospitals to deliver
14 quality services in a timely manner; use only relevant quality measures for rural hospitals and set
15 minimum volume thresholds for measures to ensure statistical reliability; hold rural hospitals
16 harmless from financial penalties for quality metrics that cannot be assessed due to low statistical
17 reliability; and create voluntary monthly payments for primary care that would give physicians the
18 flexibility to deliver services in the most effective manner with an expectation that some services
19 will be provided via telehealth or telephone. The AMA also encourages transparency among rural
20 hospitals regarding their costs and quality outcomes, supports better coordination of care between
21 rural hospitals and networks of providers where services are not able to be appropriately provided
22 at a particular rural hospital, and encourages employers and rural residents to choose health plans
23 that adequately and appropriately reimburse rural hospitals and physicians.
24

25 CONCLUSIONS

26
27 With an overall sicker population and larger geographical area to cover, rural LHDs are challenged
28 to meet the needs of their population with less funding and fewer, well-trained staff. Ultimately,
29 residents in rural communities should have equitable access to the essential and foundational public
30 health services provided by the public health system in other jurisdictions.¹² To achieve this,
31 research is needed to determine the needs and models for delivering public health services in rural
32 communities as well as best practices for addressing health behaviors and the social determinants
33 of health in these communities.¹²
34

35 While examples of using telehealth during the COVID-19 pandemic and CSJ are helpful, there’s
36 little in the published literature regarding successful models for increasing population level public
37 health activities in rural communities. This is likely in part due to rural LHDs having little capacity
38 and funding to participate in research and publish results. Unlike their urban counterparts, rural
39 LHDs also lack a specific advocacy organization.
40

41 The lack of health care available in rural jurisdictions also contributes in part to the lack of
42 essential and foundational public health services provided in rural communities, with rural LHDs
43 often left to fill the gap in the absence of other sources of health care. While not directly the focus
44 of this report, the AMA has extensive policy addressing access to rural health care.
45

46 RECOMMENDATIONS

47
48 The Council on Science and Public Health recommends that the following be adopted, and the
49 remainder of the report be filed.

- 1 1. That our AMA amend Policy H-465.994, “Improving Rural Health,” by addition and deletion
2 to read as follows:

3
4 1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals
5 for improving rural health care and public health, (b) urges physicians practicing in rural areas
6 to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies
7 and proposals for improving rural health care and public health to the profession, other
8 concerned groups, and the public.

9
10 2. Our AMA will work with other entities and organizations interested in public health to:

- 11 • Encourage more research to identify the unique needs and models for delivering public
12 health and health care services in rural communities.
13 • Identify and disseminate concrete examples of administrative leadership and funding
14 structures that support and optimize local, community-based rural public health.
15 • Develop an actionable advocacy plan to positively impact local, community-based rural
16 public health including but not limited to the development of rural public health networks,
17 training of current and future rural physicians and public health professionals in core public
18 health techniques and novel funding mechanisms to support public health initiatives that
19 are led and managed by local public health authorities.
20 • Advocate for adequate and sustained funding for public health staffing and programs.
21 • ~~Study efforts to optimize rural public health.~~

- 22
23 2. That our AMA amend Policy D-440.924, “Universal Access for Essential Public Health
24 Services” by addition and deletion to read as follows:

25
26 Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the
27 Foundational Public Health Services to protect and promote the health of all people in all
28 communities updating The Core Public Health Functions Steering Committee’s “The 10
29 Essential Public Health Services” to bring them in line with current and future public health
30 practice; (2) encourages state, local, tribal, and territorial public health departments to pursue
31 accreditation through the Public Health Accreditation Board (PHAB); (3) will work with
32 appropriate stakeholders to develop a comprehensive list of minimum necessary programs and
33 services to protect the public health of citizens in all state and local jurisdictions and ensure
34 adequate provisions of public health, including, but not limited to clean water, functional
35 sewage systems, access to vaccines, and other public health standards; and (4) will work with
36 the National Association of City and County Health Officials (NACCHO), the Association of
37 State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers
38 for Disease Control and Prevention (CDC), and other related entities that are working to assess
39 and assure appropriate funding levels, service capacity, and adequate infrastructure of the
40 nation’s public health system, including for rural jurisdictions. (Amend HOD Policy)

- 41
42 3. That our AMA reaffirm Policy H-478.980, “Increasing Access to Broadband Internet to
43 Reduce Health Disparities.” (Reaffirm HOD Policy)

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

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-22)

Introduced by: New York

Subject: Air Quality and the Protection of Citizen Health

Referred to: Reference Committee D

1 Whereas, The upper Hudson River, located in three counties of New York State has been the
2 site of multiple pollution issues (Ciba-Geigy – Chromium and Cyanide in the Feeder Canal,
3 GE – PCB in the Hudson River)^{2,3}; and
4

5 Whereas, The Wheelabrator Waste to Energy Plant and the Leigh Cement Facility are emitting
6 over 300 pounds of heavy metals into the air each year for the last 25 years⁴; and
7

8 Whereas, Emission compliance is tested only every 30 months⁵ and there is a history of
9 violations to EPA guidelines⁶; and
10

11 Whereas, These metallic elements do not disappear from the environment, are considered
12 systemic toxicants that are known to induce multiple organ damage, even at lower levels of
13 exposure, and they are also classified as human carcinogens (known or probable) according to
14 the U.S. Environmental Protection Agency, and the International Agency for Research on
15 Cancer⁷; and
16

17 Whereas, Study of the potential ecological risks has revealed that the degree of ecological harm
18 caused by heavy metal dust is very strong in both urban and suburban areas⁸; therefore be it
19

20 RESOLVED, That our American Medical Association review the Environmental Protection
21 Agency's guidelines for monitoring the air quality which is emitted from smokestacks, taking into
22 consideration the risks to citizens living downwind of smokestacks (Directive to Take Action);
23 and be it further
24

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

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

Received: 03/22/22

References:

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-22)

Introduced by: New York

Subject: Support for Impairment Research

Referred to: Reference Committee D

- 1 Whereas, There has been a proliferation of new and designer recreational drugs, most of which
2 are difficult to detect; and
3
4 Whereas, One of the leading causes of motor vehicle operator (driver) impairment is fatigue
5 without substance use or abuse; and
6
7 Whereas, There are no biochemical or physiological assays for fatigue, akin to breathalyzer
8 readings for ethanol, leading to undercounting and under appreciation of its relevance; and
9
10 Whereas, Evidence is lacking for reliable and reproducible methods of impairment assessment
11 unrelated to the few easily detectable intoxicants; and
12
13 Whereas, The United States Department of Defense (DOD), the Defense Advanced Research
14 Projects Agency (DARPA), and the Institute of Medicine (IOM) have conducted extensive
15 research on neurocognitive testing to assess alertness and impairment; therefore be it
16
17 RESOLVED, That our American Medical Association study the impairment of drivers and other
18 operators of mechanized vehicles by substances, fatigue, medical or mental health conditions,
19 and that this report include whether there are office or hospital-based methods to efficiently and
20 effectively assess impairment of drivers with recommendations for further research that may be
21 needed. (Directive to Take Action)

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

Received: 03/22/22

References:

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-22)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination and Support for Flexible Family Leave

Referred to: Reference Committee D

1 Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and
2 their experiences with workplace discrimination indicated that 77.9% of the respondents
3 experienced some form of discrimination;¹ and
4

5 Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender
6 discrimination and 35.8% reported experiencing maternal discrimination, which is defined as
7 self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;¹ and
8

9 Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the
10 Civil Rights Act of 1964, protects individuals from discrimination based on protected class such
11 as, sex, gender and pregnancy;² and
12

13 Whereas, The Fair Labor Standards Act includes some breastfeeding protections and
14 requirements for maternity leave but no protections for any additional leaves dealing with
15 parenting needs ;³ and
16

17 Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in
18 physicians experiencing maternal discrimination compared to 33.9% burnout in those not
19 experiencing maternal discrimination) even prior to the pandemic;¹ and
20

21 Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women
22 who are employed full time spend an additional 8.5 hours per week on childcare and other
23 domestic activities which was before the demands of virtual schooling and homeschooling;⁴ and
24

25 Whereas, Homeschooling rates have more than tripled during the pandemic due to educational
26 needs and health concerns;⁶ and
27

28 Whereas, Across the country almost two-thirds of parents say their children have switched to
29 online learning which requires adult supervision;⁷ and
30

31 Whereas, Mothers of young children have lost four to five times as many work hours compared
32 to fathers in the pandemic due to women taking on the majority of childcare responsibilities;⁷
33 and
34

35 Whereas, Male physicians are increasingly expressing interest in flexible family leave and work
36 options, yet female physicians continue to bear primary responsibility for caregiving and may
37 face more challenges in aligning their career goals with family needs; and

1 Whereas, Conflicts between work and life responsibilities, which have been exacerbated due to
2 the pandemic, can have adverse consequences for women physicians, leading to further
3 discrimination; and
4

5 Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion
6 of paid parental leave; calls for improved social and economic support for paid family leave to
7 care for newborns, infants and young children; and advocates for federal tax incentives to
8 support early child care and unpaid child care by extended family members; therefore be it
9

10 RESOLVED, That our American Medical Association encourage key stakeholders to implement
11 policies and programs that help protect against maternal discrimination and promote work-life
12 integration for physician parents, which should encompass prenatal care, parental leave, and
13 flexibility for childcare (New HOD Policy); and be it further
14

15 RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in
16 legislation that provides protections and considerations for paid parental leave for issues of
17 health and childcare. (New HOD Policy)

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

Received: 04/01/22

References:

1. Adesoye T, Mangurian C, Choo EK, et al. Perceived Discrimination Experienced by Physician Mothers and Desired Workplace Changes: A Cross-sectional Survey. *JAMA Intern Med.* 2017;177(7):1033-1036.
2. U.S. Equal Employment Opportunity Commission. Available at <https://www.eeoc.gov/laws/types/>. Accessed 3/2/2020.
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4. Templeton K, Bernstein CA, Sukhera J, et al. Gender-Based Differences in Burnout: Issues Faced by Women Physicians. Available at <https://nam.edu/gender-based-differences-in-burnout-issues-faced-by-women-physicians/>. Accessed 3/10/2020.
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6. Henderson T. Mothers Are 3 Times More Likely Than Fathers to Have Lost Jobs in Pandemic. Pew Stateline Article. 9/28/2020. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/09/28/mothers-are-3-times-more-likely-than-fathers-to-have-lost-jobs-in-pandemic>

RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
 5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
 6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
 7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
 8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
 9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
 10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
 11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
 12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
 13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
 14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
- Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

Support of Human Rights and Freedom H-65.965

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

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

9.5.5 Gender Discrimination in Medicine

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

(a) Promote fairness in the workplace, including providing for:

(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;

(ii) on-site child care services for dependent children;

(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.

(b) Promote fairness in academic medical settings by:

(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;

(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;

(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;

(iv) structuring the mentoring process through a fair and visible system.

(c) Take steps to mitigate gender bias in research and publication.

[AMA Principles of Medical Ethics: II,VII](#)

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

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(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: Weapons in Correctional Healthcare Settings

Referred to: Reference Committee D

- 1 Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being
2 introduced into some Mental Health Units in federal correctional facilities in 2021; and
3
- 4 Whereas, Physicians in federal correctional healthcare settings who are employed by the
5 Federal Bureau of Prisons are considered law enforcement officers; and
6
- 7 Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State
8 Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for
9 Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks,
10 tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and
11
- 12 Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents
13 of serious workplace violence (requiring days off work) are four times more common in
14 healthcare settings than in private industry, so an intentional plan and response to reduce
15 workplace violence is indicated (OSHA, 2015); and
16
- 17 Whereas, The American Psychiatric Association does not support the use of weapons as a
18 clinical response in the management of patient behavioral dyscontrol in emergency room and
19 inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA,
20 2018); and
21
- 22 Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using
23 clinical approaches. These clinical approaches will typically involve psychological interpersonal
24 interventions and when less restrictive alternatives fail, the use of involuntary emergency
25 medication, physical seclusion, and physical or mechanical restraint, following guidelines issued
26 by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and
27
- 28 Whereas, The National Commission on Correctional Health Care supports the active prevention
29 of violence through nonphysical methods to prevent and/or control disruptive behaviors
30 including a balanced biopsychosocial approach (NCCHC, 2013); and
31
- 32 Whereas, Our *AMA Code of Ethics* notes "Physicians have civic duties, but medical ethics do
33 not require a physician to carry out civic duties that contradict fundamental principles of medical
34 ethics, such as the duty to avoid doing harm" (AMA Code of Ethics Opinion 9.7.2); and
35
- 36 Whereas, Our *AMA Code of Ethics* notes "Individual physicians who provide care under court
37 order should: Participate only if the procedure being mandated is therapeutically efficacious and
38 is therefore undoubtedly not a form of punishment or solely a mechanism of social control."

1 (AMA Code of Ethics Opinion 9.7.2); and

2
3 Whereas, Our *AMA Code of Ethics* notes “Preserving opportunity for physicians to act (or
4 to refrain from acting) in accordance with the dictates of conscience in their professional
5 practice is important for preserving the integrity of the medical profession as well as the
6 integrity of the individual physician, on which patients and the public rely” (AMA Code of
7 Ethics Opinion 1.1.7); and

8
9 Whereas, The presence of weapons from any source is likely to increase safety concerns
10 without added safety for patients or staff; and

11
12 Whereas, The presence of weapons within any healthcare facility may erode the physician-
13 patient relationship, limit access to care, and increase the vulnerability of those individuals and
14 communities who have experienced systemic racism and violence from law enforcement
15 officers (Liebschutz et al., 2010); and

16
17 Whereas, The presence of weapons within correctional healthcare facilities may trigger
18 aggression and agitation worsening behavioral dysregulation via the weapons effect (Berkowitz
19 and Le Page, 1967); therefore be it

20
21 RESOLVED, That our American Medical Association advocate that physicians not be required
22 to carry or use weapons in correctional facilities where they provide clinical care (Directive to
23 Take Action); and be it further

24
25 RESOLVED, That our AMA study and make recommendations regarding the presence of
26 weapons in correctional healthcare facilities. (Directive to Take Action)

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

Received: 04/05/22

References:

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- American Psychiatric Association (2018) Position Statement on Weapons Use in Hospitals and Patient Safety Accessed 2/22/21 <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Weapons-Use-in-Hospitals-and-Patient-Safety.pdf>
- AMA Code of Ethics (2021) Code of Medical Ethics Opinion 1.1.7 Physician Exercise of Conscience Accessed 2/22/21 <https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience>
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- National Commission on Correctional Health Care (2013) Position Statement: Prevention of Violence in Correctional Settings Accessed 2/22/21 https://www.ncchc.org/filebin/Positions/Prevention_of_Violence.pdf
- OSHA (2015) Workplace Violence in Healthcare: Understanding the Challenge. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3826 - 12/2015 <https://www.osha.gov/Publications/OSHA3826.pdf>

RELEVANT AMA POLICY

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977

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

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present

Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Policing Reform H-65.954

Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.

Citation: Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21

Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in

crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.

Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21

Preventing Violent Acts Against Health Care Providers D-515.983

Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training.

Citation: Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, A-16

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA 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: 405
(A-22)

Introduced by: Medical Student Section

Subject: Universal Childcare and Preschool

Referred to: Reference Committee D

- 1 Whereas, In the 2019-2020 school year, only 34% of 4-year-olds and 6% of 3-year-olds were
2 enrolled in state pre-kindergarten¹; and
3
- 4 Whereas, The COVID-19 pandemic caused a sharp decline in preschool enrollment, quality
5 standards, teacher qualifications, and state funding^{1,2}; and
6
- 7 Whereas, Research has demonstrated that participation in preschool improves access to
8 pediatric preventive care and is linked to decreases in child mortality, increases in
9 immunizations, reductions in hospitalizations for accidents or injuries, and additional avenues
10 for screening, diagnosis, and care for pediatric patients with ADHD³⁻⁵; and
11
- 12 Whereas, Early care and education programs have been shown to lead to long-term
13 improvements in cardiovascular and metabolic health through adolescence and adulthood, as
14 well as reduced smoking and obesity^{3,6-8}; and
15
- 16 Whereas, Universal child care and preschool are avenues for capturing child maltreatment
17 cases because of the crucial role that school personnel play in recognizing, reporting, and
18 preventing child abuse and neglect⁹; and
19
- 20 Whereas, Childcare attendance is associated with improved cognitive abilities and mitigates the
21 increase in externalizing behaviors observed in children exposed to early adversity¹⁰; and
22
- 23 Whereas, Children who participate in early childhood education have higher kindergarten scores
24 in reading, mathematics, cognitive flexibility, and approaches to learning¹¹; and
25
- 26 Whereas, A 2021 JAMA Pediatrics study determined that, for children of mothers with a lower
27 education level, childcare attendance was positively associated with academic achievement at
28 age 16¹²; and
29
- 30 Whereas, High-quality childcare and early education are shown to have positive effects on the
31 mother-child relationship, maternal wellbeing, and physical and mental, short- and long-term
32 health outcomes for children^{3,13-15}; and
33
- 34 Whereas, Maternal mental health, including maternal depression, and life satisfaction improved
35 after implementation of universal child care in Canada and maternal wellbeing improved after
36 implementation of publicly funded childcare in Germany¹⁶⁻¹⁷; and
37
- 38 Whereas, In 2020, the Department of Labor estimated that there were 20.1 million employed
39 Americans with children under the age of six¹⁸; and

1 Whereas, A 2020 study of childcare facility closures published in JAMA Health Forum indicated
2 that “state-level childcare facility closures were associated with greater reductions in
3 employment among women compared to men” for parents of children under the age of six¹⁹;
4 and

5
6 Whereas, There are significant racial and ethnic inequities in access to federal childcare
7 subsidies as compared to the national average of 12%, with only 7% of Native American and
8 Alaska Native, 6% of Hispanic/Latino, and 3% of Asian eligible children being served by the
9 Child Care Development Block Grant subsidies in 2016²⁰; and

10
11 Whereas, 57.3% of Hispanic/Latino and 60.2% of American Indian and Alaska Native
12 populations live in childcare deserts (defined as “areas with an insufficient supply of licensed
13 childcare”), compared to the overall population at 50.5%²¹; and

14
15 Whereas, Children from families with high socioeconomic status (SES) are more likely to attend
16 early childhood education programs, with 69% of kindergarteners from high SES families and
17 only 44% from low SES families¹¹; and

18
19 Whereas, The Child Care and Development Fund is the primary source of financial childcare
20 assistance for low-income families, but, according to the U.S. Department of Health & Human
21 Services, it served only 15% of the 13.3 million children meeting federal eligibility parameters in
22 2016²²; and

23
24 Whereas, Only five states, District of Columbia, New Jersey, North Carolina, Oklahoma, and
25 West Virginia, fully fund high-quality full-day pre-K, as determined by quality benchmarks set by
26 the National Institute for Early Education Research¹; and

27
28 Whereas, There is a growing recognition of the importance of universal child care and preschool
29 that is reflected by nationwide initiatives like the Senate’s Improving Child Care for Working
30 Families Act of 2021 and the Administration’s American Families Plan which will provide
31 universal free preschool and limit childcare costs to less than 7% of household income^{23,24}; and

32
33 Whereas, The American Academy of Pediatrics Council on Early Childhood published a 2016
34 position statement stating that “high-quality early education and child care for young children
35 improves physical and cognitive outcomes for the children and can result in enhanced school
36 readiness”²⁵; and

37
38 Whereas, While our AMA has some existing policies (D-200.974, H-310.912, G-600.115, H-
39 95.916, H-440.970, H-150.927, and H-245.979) supporting access to childcare for healthcare
40 professionals and patients in substance use treatment facilities, funding for Head Start (a
41 federal childcare and preschool program for low-income families), and public health protections
42 in childcare settings, our AMA does not currently have policy on universal, affordable access to
43 childcare; and

44
45 Whereas, While AMA Policy H-60.917 states that our AMA “will issue a call to action to...to
46 propose strategies...to further the access of all children to...early childhood education,” this does
47 not ask our AMA to advocate for proposed strategies currently being debated in Congress and
48 state governments, and “early childhood education” in that context appears to refer to existing
49 public education from kindergarten to third grade and not specifically childcare or preschool,
50 which are more limited in availability and require greater advocacy to expand; therefore be it

1 RESOLVED, That our American Medical Association advocate for universal access to high-
2 quality and affordable childcare and preschool. (Directive to Take Action)

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

Received: 04/08/22

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RELEVANT AMA POLICY

Supporting Child Care for Health Care Professionals D-200.974

Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees). Res. 309, A-21

Preserving Childcare at AMA Meetings G-600.115

Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings. Res. 602, I-19

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that: (a) decrease the educational opportunity gap; (b) increase participation in high school Advanced Placement courses; and (c) increase the high school graduation rate. Res. 910, I-16; Appended: Res. 410, A-19; Appended: CME Rep. 5, A-21

Childcare Availability for Persons Receiving Substance Use Disorder Treatment H-95.916

Our AMA supports the implementation of childcare resources in existing substance use treatment facilities and acknowledges childcare infrastructure and support as a major priority in the development of new substance use programs. Res. 519, A-19

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

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and

promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

Res. 215, I-16; Appended: BOT Rep. 11, A-19

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

Citation: CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19; Modified: Res. 207, I-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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-22)

Introduced by: American Association of Public Health Physicians

Subject: COVID-19 Preventive Measures for Correctional Facilities: AMA Policy
Position

Referred to: Reference Committee D

- 1 Whereas, Correctional facilities are, by their nature, congregate facilities[i]; and
2
3 Whereas, Those incarcerated should be tested for COVID upon entry when recommended by
4 the CDC; and if positive isolated for time periods recommended by the CDC; and
5
6 Whereas, Those incarcerated, and test negative are quarantined prior to enter into the general
7 population according to current CDC guidelines [ii]; and
8
9 Whereas, Despite these measures there may continue to be a higher rate of COVID-19
10 transmission in correctional facilities than in the local communities;[iii] and
11
12 Whereas, The probable source of these COVID-19 infections is by those entering and exiting on
13 a frequent, sometimes daily, basis; and
14
15 Whereas, Less than 50% of correctional employees are fully vaccinated in accordance with
16 CDC guidelines against COVID-19 [iv]; and
17
18 Whereas, Requiring vaccination does not result in increased employment vacancies [v] [vi] [vii];
19 and
20
21 Whereas, COVID vaccination and masks have been shown to decrease the spread of
22 COVID-19 and the need for hospitalization [viii]; and
23
24 Whereas, Our AMA has taken a position on appropriate preventive measures [ix]; and
25
26 Whereas, This resolution should not be considered a mandate but as a position statement,
27 therefore be it
28
29 RESOLVED, That our American Medical Association advocate for all employees working in a
30 correctional facility to be up to date with vaccinations against COVID-19, unless there is a valid
31 medical contraindication/religious exception (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA advocate for all employees not up to date with vaccination for
34 COVID-19 to be COVID rapid tested each time they enter a correctional facility (Directive to
35 Take Action); and be it further

1 RESOLVED, That our AMA advocate for correctional facility policies that require non-employed,
2 non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for
3 COVID-19 or show proof of negative COVID test completed within 24 hours prior to each entry
4 into a correctional facility (Directive to Take Action); and be it further

5
6 RESOLVED, That our AMA advocate that all people inside a correctional facility wear an
7 appropriate mask at all times, except while eating or drinking or at a safe (6 ft.) distance from
8 anyone else if local transmission rate is above low risk as determined by the Centers for
9 Disease Control and Prevention (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA advocate that correctional facilities be able to request and receive
12 all necessary funding for the above endemic COVID-19 vaccination and testing. (Directive to
13 Take Action)

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

Received: 04/08/22

[i] Mary Devereaux Hutton et al., Tuberculosis in Nursing Homes and Correctional Facilities: results of a 29-State Survey, CDC, at 2 (Nov. 1990), <https://bit.ly/3i51ySj>; see also, e.g., Joseph A. Bick, Infection Control in Jails and Prisons, 45 Clinical Infectious Diseases 1047 (2007), <https://bit.ly/3qrND34>.

[ii] <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

[iii] COVID-19, State of New Jersey Department of Corrections ("NJDOC"), <https://bit.ly/3Hj0yKQ>

[iv] With the majority of corrections officers declining the COVID-19 vaccine, incarcerated people are still at serious risk.

<https://www.prisonpolicy.org/blog/2021/04/22/vaccinerefusal/>

[v] Jack J. Barry et al., Unvaccinated Workers Say They'd Rather Quit Than Get a Shot, but Data Suggest Otherwise, Scientific American (Sept. 24, 2021), <https://bit.ly/3kUYKOT>.

[vi] Compare New Jersey COVID-19 Dashboard, (listing 1,835,533 cases in New Jersey), with QuickFacts: New Jersey, U.S. Census Bureau, <https://bit.ly/3GcGhFy> (last visited Feb. 4, 2022) (listing New Jersey population as 9,267,130).

[vii] Compare COVID-19, (listing 10,139 positive COVID-19 cases among incarcerated populations in NJDOC facilities), with Offender Characteristics Report on January 1, 2021, NJDOC, <https://bit.ly/3L88jpt> (in most recent publicly available data, listing total incarcerated individuals in NJDOC facilities as 12,808) and Total Inmates in New Jersey State Correctional Institutions and Satellite Units, State of New Jersey Department of Corrections (2020), <https://bit.ly/3ukd4pJ> (listing total incarcerated individuals in NJDOC facilities as 18,477 in 2020)

[viii] What do we know about covid vaccines and preventing transmission? BMJ 2022;376:o298

[ix] Press Release, American Medical Ass'n, AMA, AHA, ANA urge vaccinations as U.S. reaches 750,000 COVID-19 deaths (Nov. 4, 2021), <https://bit.ly/3C07CIS>.

[x] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html?s_cid=11747:cdc%20up%20to%20date%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-22)

Introduced by: American Thoracic Society

Subject: Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections

Referred to: Reference Committee D

1 Whereas, Law enforcement and correctional officers at the bedside of a patient in their custody
2 have ethical guidelines, legal obligations, and operating procedures that are separate--and
3 potentially in tension with--those of the various clinicians caring for that patient in an acute care
4 setting. Lack of clarity or disagreement can arise even when all parties are acting in good faith
5 to fulfil their respective duties (1,2); and
6
7 Whereas, Clinicians in acute care environments often lack clear guidance on when and how law
8 enforcement or correctional officers can or should dictate parameters of patient care in ways
9 that are not clinically indicated, including but not limited to: restraint and officer presence at the
10 bedside, documentation of injuries, collection of evidence, laboratory testing, end-of-life decision
11 making, organ donation, visitor restrictions, and sharing of protected health information (PHI)
12 (3); and
13
14 Whereas, Hospital liaison teams to help guide interactions between clinicians and law
15 enforcement agencies may improve communication and coordination while also providing
16 patients, their surrogates, and members of the healthcare team with autonomy and privacy
17 protections required by law and in concordance with professional ethical standards (4,5); and
18
19 Whereas, Existing AMA policy does not provide adequate actionable guidance to clinicians
20 and/or law enforcement officials at the bedside, including policy surrounding disclosure of PHI to
21 law enforcement (H-315.975); therefore be it
22
23 RESOLVED, That our American Medical Association study best practices for interactions
24 between hospitals, clinicians, and members of law enforcement or correctional agencies to
25 ensure that patients in custody of such law enforcement or correctional agencies (including
26 patients without decision-making capacity), their surrogates, and the health care providers
27 caring for them are provided the autonomy and privacy protections afforded to them by law and
28 in concordance with professional ethical standards and report its findings to the AMA House of
29 Delegates by the 2023 Annual Meeting. (Directive to Take Action)

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

Received: 04/08/22

1. Law Enforcement Code of Ethics: International Association of Chiefs of Police; [Available from: <https://www.theiacp.org/resources/law-enforcement-code-of-ethics>.
2. Code of Medical Ethics: American Medical Association; 2022 [Available from: <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview>.
3. Griffith MF, O'Brien JK, Sergew A, Wynia MK, Carno M, Akgün KM. Profiling, Privacy, and Protection: Ethical Guidance When Police Are Present at Bedside. *Ann Am Thorac Soc*. 2022.
4. Hospital Coordination with Law Enforcement: Hospital Guidance Document: Greater New York Hospital Association; [Available from: https://www.gnyha.org/wp-content/uploads/2017/08/NYPD_Coordination_FINAL_6Dec2016.pdf.
5. Guidelines for Releasing Patient Information to Law Enforcement American Hospital Association and National Association of Police Organizations; 2018 [Available from: <https://www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf>.

RELEVANT AMA POLICY

Police, Payer, and Government Access to Patient Health Information H-315.975

- (1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
 - (2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
 - (3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
 - (4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
 - (5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.
- Citation: Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmed: BOT Rep. 16, I-21

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Citation: Res. 232, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-22)

Introduced by: Illinois

Subject: Supporting Increased Research on Implementation of Nonviolent
De-escalation Training and Mental Illness Awareness in Law Enforcement

Referred to: Reference Committee D

- 1 Whereas, The risk for an individual with untreated mental illness of being killed during a police
2 incident is one in four; and
3
4 Whereas, Government agencies collect data from independent databases as they are more
5 complete than data procured by government agencies, however the media and independent
6 sources have incomplete data due to a lack of a national government database; and
7
8 Whereas, This leads to a feedback loop of misinformation where the true statistics surrounding
9 police-related fatalities are unknown; and
10
11 Whereas, Though improvements have been made to the Bureau of Justice Statistics' Arrest-
12 Related Deaths (ARD) program, there is still an estimated 31-41% cases of fatal shootings that
13 are still believed to be missed, due to the program not meeting the agency's quality standards;
14 and
15
16 Whereas, These downfalls in reporting of fatal police shootings by government agencies miss
17 the target even further in regard to mental illness's role in these deadly encounters, leading to
18 audits due to inability to meet the agencies quality standards; and
19
20 Whereas, De-escalation tactics and techniques are actions used by officers, when safe and
21 feasible without compromising law enforcement priorities, that seek to minimize the likelihood of
22 the need to use force during an incident and increase the likelihood of voluntary compliance;
23 and
24
25 Whereas, De-escalation tactics such as crisis intervention training, when used by officers are
26 safe without compromising law enforcement priorities, and minimize the need for force in
27 encounters, and increase the likelihood of voluntary compliance by a civilian; and
28
29 Whereas, De-escalation training has been shown to be the most successful at increasing self-
30 reported knowledge and confidence amongst trainees; and
31
32 Whereas, Greater knowledge of causes and precipitating factors of aggression and violence as
33 well as improved capabilities to handle those emotions promotes prevention and management
34 of these behaviors; therefore, be it
35
36 RESOLVED, That our American Medical Association support increased research on non-violent
37 de-escalation tactics for law enforcement encounters with the mentally ill (New HOD Policy);
38 and be it further

1 RESOLVED, That our AMA support research of fatal encounters with law enforcement and the
2 prevention thereof. (New HOD Policy)

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

Received: 04/08/22

References:

1. Fuller DA, Lamb HR, Biasotti M, Snook J. Overlooked in the Undercounted - The Role of Mental Illness in Fatal Law Enforcement Encounters. Overlooked in the Undercounted - Treatment Advocacy Center. <https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf> Published December 2015.
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3. Banks D, Ruddle P, Kennedy E, Planty MG. Arrest-Related Deaths Program Redesign Study, 2015-16: Preliminary Findings. Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2016. No. NCJ 250112
4. Diaz A. 8.100 - De-Escalation. 8.100 - De-Escalation - Police Manual. <https://www.seattle.gov/police-manual/title-8--use-of-force/8100---de-escalation> Published September 15, 2019.
5. Engel RS, McManus HD, Herold TD. The Deafening Demand for De-escalation Training: A Systematic Review and Call for Evidence in Police Use of Force Reform. https://www.theiacp.org/sites/default/files/IACP_UC_De-escalation%20Systematic%20Review.pdf Published 2017

RELEVANT AMA POLICY

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

Our AMA:

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

Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-22)

Introduced by: Illinois

Subject: Increasing HPV Vaccination Rates in Rural Communities

Referred to: Reference Committee D

1 Whereas, Recent studies have shown only 28.3% of adolescents living in non-metropolitan
2 statistical areas of Illinois had received all recommended doses of the HPV vaccine as
3 compared to 61.2% of adolescents living in metropolitan statistical areas around the state who
4 had received all recommended doses; and

5
6 Whereas, The disparity between urban and rural HPV vaccine rates is similar across the United
7 States, with lower vaccination rates in rural areas; and

8
9 Whereas, In the US it is estimated there were 32,100 cases of HPV related cancers from 2012-
10 2016 that are targets for the 9vHPV vaccine; therefore be it

11
12 RESOLVED, That our American Medical Association advocate for increased HPV vaccination
13 access and education in rural communities. (Directive to Take Action)

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

Received: 04/08/22

References:

"2018 Adolescent Human Papillomavirus (HPV) Vaccination Coverage Dashboard." 2018 Adolescent Human Papillomavirus (HPV) Vaccination Coverage Dashboard, Centers for Disease Control and Prevention, 2018, www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/dashboard/2018.html

Senkomago V, Henley SJ, Thomas CC, Mix JM, Markowitz LE, Saraiya M. Human Papillomavirus-Attributable Cancers-United States, 2012-2016. MMWR Morb Mortal Wkly Rep 2019; 68: 724-728 <https://www.cdc.gov/mmwr/volumes/68/wr/mm6833a3.htm>

RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Citation: (Res. 503, A-07; Appended: Res. 6, A-12)

Human Papillomavirus (HPV) Inclusion in School Education Curricula D-170.995

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Citation: Res. 418, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 404, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-22)

Introduced by: Illinois

Subject: Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention

Referred to: Reference Committee D

1 Whereas, There are three phases of schizophrenia: prodromal, active and residual; and
2
3 Whereas, Prepsychotic prodromal stage lasts for a mean duration of 4.8 years and a psychotic
4 prephase lasts for a mean duration of 1.3 years; and
5
6 Whereas, Almost 70% of people living with schizophrenia receive inadequate treatment; and
7
8 Whereas, The early detection of symptoms of the prodrome of psychotic illness in order of
9 increased frequency include: reduced concentration and attention, reduced drive and motivation
10 and anergia, depressed mood, sleep disturbance, anxiety, social withdrawal, suspiciousness
11 and deterioration in role functioning, irritability; and
12
13 Whereas, Late detection and treatment of prolonged psychosis result in worse outcomes; and
14
15 Whereas, If early prodromal symptoms of a psychotic illness are detected, referral for further
16 psychiatric evaluation should be considered; and
17
18 Whereas, Establishing care with patients demonstrating prodromal symptoms of a psychotic
19 illness is an important part of their current and future outcomes; and
20
21 Whereas, Only a systematic implementation of these models of care in the national health care
22 systems will render these strategies accessible to the 23 million people worldwide suffering from
23 the most severe psychiatric disorders; therefore be it
24
25 RESOLVED, That our American Medical Association work with the American Psychiatric
26 Association and other entities to support research of establishing education programs to teach
27 high school and university staff to recognize the early prodromal symptoms of schizophrenia to
28 increase early intervention. (Directive to Take Action)

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

Received: 04/08/22

References:

- 1.Larson MK, Walker EF, Compton MT. Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. *Expert Rev Neurother*. 2010;10(8):1347-1359. doi:10.1586/ern.10.93
- 2.Häfner H, Maurer K. Early detection of schizophrenia: current evidence and future perspectives. *World Psychiatry*. 2006;5(3):130-138.
- 3.Schizophrenia. World Health Organization. <https://www.who.int/news-room/fact-sheets/detail/schizophrenia>. October 4, 2019.
- 4.Fusar-Poli P, McGorry PD, Kane JM. Improving outcomes of first-episode psychosis: an overview. *World Psychiatry*. 2017;16(3):251-265. doi:10.1002/wps.20446

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-22)

Introduced by: Michigan

Subject: Anonymous Prescribing Option for Expedited Partner Therapy

Referred to: Reference Committee D

- 1 Whereas, Sexually transmitted infections (STIs) reached an all-time high in the United States in
2 2018 with more than 580,000 cases of gonorrhea and 1.7 million cases of chlamydia, the
3 highest number of chlamydia cases ever reported to the Centers for Disease Control and
4 Prevention (CDC); and
5
6 Whereas, Some data suggests that 40 to 70 percent of male partners do not receive STI
7 treatment; and
8
9 Whereas, Reinfection rates of chlamydia and gonorrhea in women are high, estimated to be
10 13.9 percent and 11.7 percent, respectively; and
11
12 Whereas, Untreated STIs can result in adverse health outcomes including pelvic inflammatory
13 disease, infertility, ectopic pregnancy, and increased HIV risk; and
14
15 Whereas, Expedited Partner Therapy (EPT) is the clinical practice in which a patient diagnosed
16 with chlamydia or gonorrhea may be given medications for themselves and their sex partners
17 without the health care provider first examining the partner; and
18
19 Whereas, Evidence indicates that EPT has improved clinical effectiveness in decreasing
20 recurrent infection compared to other methods of partner treatment; and
21
22 Whereas, EPT has been found to be cost-saving and cost-effective, improves notification of
23 sexual partners of the STI diagnosis, and safe as severe reactions to treatment are so rare that
24 there are no reported percentages; and
25
26 Whereas, Physicians have an ethical duty to not only help their patients but also improve public
27 health, which includes the treatment of their patients' partner(s); and
28
29 Whereas, The practice of EPT is supported by the CDC, the American College of Obstetricians
30 and Gynecologists, the American Academy of Family Physicians, the American Academy of
31 Pediatrics, and the Society for Adolescent Health and Medicine; and
32
33 Whereas, Existing AMA policy (D-440.968, H-440.868) supports the practice of EPT and
34 existing policy states it will work with the CDC to develop tools for health departments and
35 health professionals to facilitate the use of EPT; and
36
37 Whereas, Although EPT is well-supported, there is limited discussion surrounding anonymous
38 prescribing within EPT and current policies do not explicitly address this component of EPT; and

- 1 Whereas, Most electronic medical record systems do not have the ability to allow a physician to
2 prescribe medications anonymously; therefore be it
3
4 RESOLVED, That our American Medical Association work with electronic medical record
5 vendors to create an anonymous prescribing option for the purpose of expedited partner
6 therapy. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/08/22

Sources:

1. New CDC Report: STDs continue to rise in the US. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; 2019. <https://www.cdc.gov/nchhstp/newsroom/2019/2018-STD-surveillance-report-press-release.html>
2. Jamison CD, Coleman JS, Mmeje O. Improving women's health and combatting sexually transmitted infections through expedited partner therapy. *Journal of Obstetrics & Gynecology*. 2019 March; 133(3): 416-422.
3. Hosenfeld CB, Workowski KA, Berman S, Zaidi A, Dyson J, Mosure D, Bolan G, Bauer HM. Repeat infection with chlamydia and gonorrhea among females: a systematic review of the literature. *Sexually Transmitted Diseases*. 2009 August; 36(8): 478-489.
4. Expedited Partner Therapy. Centers for Disease Control and Prevention; 2019. <https://www.cdc.gov/std/ept/default.htm>
5. Althaus CL, Turner KM, Mercer CH, Auguste P, Roberts TE, Bell G, Herzog SA, Cassell JA, Edmunds WJ, White PJ, Ward H, Low N. Effectiveness and cost-effectiveness of traditional and new partner notification technologies for curable sexually transmitted infections: observational study, systematic reviews, and mathematical modelling. *Health Technologies Assessment*. 2014 January; 18(2): 1-100.
6. Gannon-Loew KE, Holland-Hall C, Bonny AE. A review of expedited partner therapy for the management of sexually transmitted infections in adolescents. *Journal of Pediatric and Adolescent Gynecology*. 2017 June; 30(3): 341-348.
7. DeCoster B, Campo-Engelstein L. Expedited partner therapy: clinical considerations and public health explorations, commentary 1. *AMA Journal of Ethics*. 2016 March; 18(3): 215-228.

RELEVANT AMA POLICY

Expedited Partner Therapy (Patient-Delivered Partner Therapy) D-440.968

Our AMA will continue to work with the Centers for Disease Control and Prevention as it implements expedited partner therapy, such as through the development of tools for local health departments and health care professionals to facilitate the appropriate use of this therapy.

Citation: CSA Rep. 9, A-05; Appended: CSAPH Rep. 7, A-06; Modified: CSAPH 01, A-16

Expedited Partner Therapy H-440.868

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, chlamydia infection, and other sexually transmitted infections, as supported by scientific evidence and identified by the CDC.

Citation: Sub. Res. 928, I-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 902, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-22)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee D

1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime
2 rate on rental properties by penalizing property owners if repeated incidents of nuisance activity
3 occur over a set period of time (typically 12 months)¹; and
4

5 Whereas, CNOs are part of a phenomenon called “third-party policing,” through which cities
6 require private citizens--in this case property owners--to address criminal or otherwise
7 undesirable behaviors¹; and
8

9 Whereas, Punishments for violating CNOs may range from warning letters and fines to evictions
10 and building closures, and often involve a “nuisance point system” where a certain number of
11 accumulated points will result in eviction and other actions¹; and
12

13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though it
14 is commonly defined as the amount of contact with emergency services, first responders, and
15 police, for criminal behavior that occurs on or near the property, or “alleged nuisance conduct”
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and
17 others)²; and
18

19 Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of
20 2014³; and
21

22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the
23 source, of the nuisance activity, so that CNOs punish tenants who require police and
24 emergency medical assistance by making eviction a consequence of police responses to their
25 homes^{1,3,4}; and
26

27 Whereas, The reason for calling the police is not accounted for by most CNOs, so people who
28 experience mental health crises may be deemed perpetrators of nuisance activity for seeking
29 emergency medical assistance at a frequency beyond the threshold established in the CNO and
30 may be threatened with eviction by their landlords¹; and
31

32 Whereas, Health crises that can count as a CNO violation include drug overdoses: public
33 records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are
34 related to a person experiencing a drug overdose, many of which explicitly include violations of
35 criminal drug abuse laws as nuisance⁵; and
36

37 Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as
38 litter, an un-mowed lawn, or an “unsightly” yard, which can be applied against residents whose
39 physical, mental, or health-related disabilities prevent them from meeting their municipality’s
40 maintenance standards¹; and

1 Whereas, Cities have fined group homes (organizations that provide community-based
2 residences for people with disabilities) after staff sought police or emergency services
3 assistance responding to their residents' medical emergencies⁵; and
4

5 Whereas, Surveys, research, and lawsuits regarding nuisance ordinance enforcement across
6 the country suggest that chronic nuisance ordinances disproportionately impact marginalized
7 populations and people of color, even when the same number of calls are made from privileged
8 neighborhoods^{2,6,7}; and
9

10 Whereas, There are an estimated 1.3 million women who are the victims of assault by an
11 intimate partner annually, and women have a 25% lifetime risk of intimate partner violence, with
12 a 40% greater chance of experiencing domestic violence for women with disabilities^{8,9}; and
13

14 Whereas, Congress acknowledges that "women and families across the country are being
15 discriminated against, denied access to, and even evicted from public and subsidized housing
16 because of their status as victims of domestic violence"⁸; and
17

18 Whereas, Domestic violence advocates' efforts in the past decades have been focused on
19 educating law enforcement on how to approach and aid victims in escaping the cycle of
20 domestic violence while maintaining their housing, but this initiative is directly threatened by
21 CNOs, as calls about domestic disturbances can result in the eviction of everyone in the
22 household^{3,10-13}; and
23

24 Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by
25 residents experiencing domestic violence, and even in cases where exceptions exist, calls
26 placed by survivors of domestic violence are regularly miscategorized and the tenants are
27 punished under the CNO regardless, discouraging victims of domestic violence from seeking
28 help in future assaults^{10,14}; and
29

30 Whereas, The use of CNOs may contribute to the "double victimization" of domestic violence
31 victims, who may be evicted because of allegations of disturbing other tenants or property
32 damage caused by their abusers¹¹; and
33

34 Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as
35 unconstitutional under the First Amendment, the reasoning being that it deterred tenants from
36 seeking police assistance, and discouraged people, including domestic violence victims, from
37 reaching out for help¹⁵; and
38

39 Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing
40 nuisance activity are limited^{7,12,14}; and
41

42 Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from
43 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such
44 behavior¹²; and
45

46 Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety,
47 and suicide, with individuals who lost legal rights to their housing and whose landlords applied
48 for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to
49 individuals who had not experienced eviction¹⁶⁻¹⁸; and

1 Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or
2 victims of domestic violence limit the opportunities for these tenants to find affordable housing in
3 the future, regardless of the circumstances in which they occurred¹³; therefore be it
4

5 RESOLVED, That our American Medical Association advocate for amendments to chronic
6 nuisance ordinances that ensure calls made for safety or emergency services are not counted
7 towards nuisance designations (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance
10 enforcement and (b) make that data publicly available to enable easier identification of
11 disparities. (New HOD Policy)

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

Received: 04/08/22

References:

1. Jarwala A, Singh S. When Disability Is a "Nuisance": How Chronic Nuisance Ordinances Push Residents with Disabilities Out of Their Homes. *Harvard Civil Rights- Civil Liberties Law Review*. July 2019;877-915.
2. Katovich S. More Than a Nuisance: The Outsized Consequence of New York's Nuisance Ordinances. *New York Civil Liberties Union*. 2018.
3. Livanos N. Crime-Free Housing Ordinances: One Call Away from Eviction. *Public Interest Law Reporter*. 2014;19(2):106-113. <http://lawecommons.luc.edu/pilr/vol19/iss2/6>.
4. I am Not a Nuisance: Local Ordinances Punish Victims of Crime. *ACLU*. <https://www.aclu.org/other/i-am-not-nuisance-local-ordinances-punish-victims-crime>. Published 2018. Accessed September 19, 2019.
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8. Pratt, S. Memorandum by Deputy Secretary for Enforcement and Programs, Office of Fair Housing & Equal Opportunity, U.S. Dep't of Housing & Urban Dev. to FHEO Office Directors and FHEO Reg'l Directors. Assessing Claims of Housing Discrimination against Victims of Domestic Violence under the Fair Housing Act and the Violence Against Women Act 4- 6 (Feb. 9, 2011).
9. Abuse of women with disabilities. American Psychological Association. <https://www.apa.org/topics/violence/women-disabilities>. Published 2019. Accessed August 25, 2019.
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12. Kastner A. The Other War at Home: Chronic Nuisance Laws and the Revictimization of Survivors of Domestic Violence. *Calif Law Rev*. 2015;103(4):1047-1079. <https://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=4297&context=californialawreview>. Accessed August 25, 2019.
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15. Bd. of Trustees of Vill. of Groton, 152 A.D.3d at 160-61.
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17. Rojas Y, Stenberg S-Å. Evictions and suicide: a follow-up study of almost 22,000 Swedish households in the wake of the global financial crisis. *J Epidemiol Community Health*. 2016;70(4):409-413. doi:10.1136/jech-2015-206419
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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953

Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

Citation: Res. 405, A-18

Insurance Discrimination Against Victims of Domestic Violence H-185.976

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

Citation: Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-22)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

- 1 Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior
2 Surveillance System indicate that 41.2% of all high school students are sexually active, and
3 11.5% have had 4 or more partners;¹ and
4
- 5 Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states
6 mandate that sex education be medically accurate, and 16 states mandate that HIV education
7 be medically accurate;^{2,3} and
8
- 9 Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate
10 and evidenced-based teaching approach which stresses abstinence and other methods of
11 contraception equally in order to prevent negative health outcomes for teenagers;⁴ and
12
- 13 Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and
14 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and
15 9.3% males) used a condom;⁵ and
16
- 17 Whereas, There is a lack of knowledge among adolescents regarding the importance of
18 condoms, dental dams and alternative barrier protection methods use during oral sex to prevent
19 the spread of sexually-transmitted infections (STIs);⁵⁻⁷ and
20
- 21 Whereas, When sex education is taught, only 20 states and D.C. require provision of
22 information on contraception;³ and
23
- 24 Whereas, Several studies have shown parents tasked with teaching their children sexual
25 education frequently needed support in information, motivation, and strategies to achieve
26 competency⁸; and
27
- 28 Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual
29 practices and behaviors;⁹ and
30
- 31 Whereas, Current sex education initiatives negatively impact transgender youth and their sexual
32 health by failing to appropriately address their behavior, leading rates of HIV more than 4 times
33 the national average, and increased likelihood to experience coerced sexual contact;⁹ and
34
- 35 Whereas, The GLSEN 2013 National School Climate Survey found that fewer than
36 5% of LGBT students had health classes that included positive representations of
37 LGBT-related topics, and among Millennials surveyed in 2015, only 12% said their sex
38 education classes covered same-sex relationships;^{2,9,10} and

1 Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement
2 (between two and seven times the rate of their heterosexual peers);¹¹ and
3

4 Whereas, When sex education is taught, seven states prohibit sex educators from discussing
5 LGBTQ relationships and identities or require homosexuality to be framed negatively if it is
6 discussed;³ and
7

8 Whereas, In 2010, the federal government redirected funds from abstinence-only programs to
9 evidence-based teen pregnancy prevention programs;¹² and
10

11 Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive
12 sexuality education, but only 4 were enacted or passed;^{2,13} and
13

14 Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools
15 across all the states taught comprehensive sex education encompassing topics including
16 pregnancy and STIs;¹⁴ and
17

18 Whereas, Since 2000, estimated medical costs of \$6.5 billion dollars were associated with the
19 treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;¹⁵
20 and
21

22 Whereas, Forty states and D.C. require school districts to involve parents in sex education
23 and/or HIV education, of which nearly all states allow parents the option to remove their child
24 from such education;¹¹ and
25

26 Whereas, Some high-risk populations such as teenagers in foster care may not be able to
27 receive adequate reproductive and sexual health education in their home;^{16,17} and
28

29 Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is
30 important and should include topics such as puberty, healthy relationships, abstinence, birth
31 control, and STIs;¹⁸ and
32

33 Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher
34 than many other industrialized countries;¹⁹⁻²¹ and
35

36 Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence
37 showing that during this time, there was a significant increase in teen use of contraceptives and
38 no significant change in teen sexual activity, highlighting the importance of education on
39 contraception in decreasing teen births²²; and
40

41 Whereas, Studies have found that abstinence-based sex education has insignificant effect on
42 improving teen birth rates and abortion rates, is not effective in delaying initiation of sexual
43 intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates
44 in states with smaller populations;²³⁻²⁵ and
45

46 Whereas, Comprehensive sex education has been shown to be effective at changing
47 knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as
48 well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI
49 rates;^{23,26-28} and

1 Whereas, The federal government has recognized the advantages of comprehensive sex
2 education and has dedicated funds for these programs including the Personal Responsibility
3 Education Program (PREP), a state-grant program from the federal government that funds
4 comprehensive sex education;^{29,30} and
5

6 Whereas, As of 2017, 41 PREP programs that emphasize abstinence and contraception equally
7 with a focus on individualized decision making have been vigorously reviewed, endorsed, and
8 funded by the HHS;²⁹ and
9

10 Whereas, Federal funding has increased the amount of funding for abstinence based programs
11 by 67% since the 2018 Consolidation of Appropriations act;³⁰ and
12

13 Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for
14 Adolescent Health and Medicine's (SAHM), and the American Public Health Association have
15 all adopted official positions of support for comprehensive sexuality education;³¹⁻³³ and
16

17 Whereas, The AMA has existing policy acknowledging the importance and public health benefit
18 of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and
19 Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986;
20 and Comprehensive Health Education H-170.977, but falls short of underscoring the importance
21 of comprehensive sex education in schools or advocating for actual implementation; and
22

23 Whereas, Lack of funding for comprehensive sex education programs means they are less likely
24 to be taught; therefore be it
25

26 RESOLVED, That our American Medical Association amend Policy H-170.968, "Sexuality
27 Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,"
28 by addition and deletion to read as follows:
29

30 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of
31 Condoms in Schools, H-170.968
32

33 ~~(1) Recognizes that the primary responsibility for family life education is in the home, and~~
34 ~~additionally s~~ Supports the concept of a complementary family life and sexuality
35 education program in the schools at all levels, at local option and direction;

36 (2) Urges schools at all education levels to implement comprehensive, developmentally
37 appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed
38 science; (b) incorporate sexual violence prevention; (c) show promise for delaying the
39 onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk
40 for contracting human immunodeficiency virus (HIV) and other sexually transmitted
41 diseases and for becoming pregnant; (d) include an integrated strategy for making
42 condoms dental dams, and other barrier protection methods available to students and
43 for providing both factual information and skill-building related to reproductive biology,
44 sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives
45 in birth control, and other issues aimed at prevention of pregnancy and sexual
46 transmission of diseases; (e) utilize classroom teachers and other professionals who
47 have shown an aptitude for working with young people and who have received special
48 training that includes addressing the needs of LGBTQ+ gay, lesbian, and bisexual youth;
49 (f) appropriately and comprehensively address the sexual behavior of all people,
50 inclusive of sexual and gender minorities; (g) include ample involvement of parents,
51 health professionals, and other concerned members of the community in the
52 development of the program; (h) are part of an overall health education program; and (i)

- 1 include culturally competent materials that are language-appropriate for Limited English
2 Proficiency (LEP) pupils;
- 3 (3) Continues to monitor future research findings related to emerging initiatives that
4 include abstinence-only, school-based sexuality education, and consent communication
5 to prevent dating violence while promoting healthy relationships, and school-based
6 condom availability programs that address sexually transmitted diseases and pregnancy
7 prevention for young people and report back to the House of Delegates as appropriate;
- 8 (4) Will work with the United States Surgeon General to design programs that address
9 communities of color and youth in high risk situations within the context of a
10 comprehensive school health education program;
- 11 (5) Opposes the sole use of abstinence-only education, as defined by the 1996
12 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- 13 (6) Endorses comprehensive family life education in lieu of abstinence-only education,
14 unless research shows abstinence-only education to be superior in preventing negative
15 health outcomes;
- 16 (7) Supports federal funding of comprehensive sex education programs that stress the
17 importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually
18 transmitted infections via comprehensive education, and also teach about including
19 contraceptive choices, abstinence, and safer sex, and opposes federal funding of
20 community-based programs that do not show evidence-based benefits; and
- 21 (8) Extends its support of comprehensive family-life education to community-based
22 programs promoting abstinence as the best method to prevent teenage pregnancy and
23 sexually-transmitted diseases while also discussing the roles of condoms and birth
24 control, as endorsed for school systems in this policy;
- 25 (9) Supports the development of sexual education curriculum that integrates dating
26 violence prevention through lessons on healthy relationships, sexual health, and
27 conversations about consent; and
- 28 (10) Encourages physicians and all interested parties to ~~conduct research and~~ develop
29 best-practice, evidence-based, guidelines for sexual education curricula that are
30 developmentally appropriate as well as medically, factually, and technically accurate.
31 (Modify Current HOD Policy)

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

Received: 04/08/22

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RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with

young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Citation: CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994

The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Citation: (Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention,

and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.

(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.

(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.

(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.

(8) Information on health and health care should be presented in an accurate and objective manner.

(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.

(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.

(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15; Reaffirmed: BOT Rep. 15, A-19

Comprehensive Health Education H-170.977

(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi)

inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.

Citation: BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904

(1) Public Information and Awareness Campaigns

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
- b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

Citation: CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-22)

Introduced by: Resident and Fellow Section

Subject: Improvement of Care and Resource Allocation for Homeless Persons in the
Global Pandemic

Referred to: Reference Committee D

1 Whereas, The COVID-19 pandemic has shown the ability to shelter in place as a social
2 determinant of health¹, and the reduction of homelessness should be a major focus of public
3 health efforts within the United States²; and
4

5 Whereas, The high prevalence of chronic health conditions such as cardiac disease, pulmonary
6 disease, liver disease, smoking and accelerated aging in the homeless population increase their
7 risk for poor disease outcomes for SARS-CoV2^{2,3}; and
8

9 Whereas, Homeless shelters and encampments are particularly susceptible to large outbreaks
10 of SARS-CoV2², and the crowding in informal settlements make self-quarantine nearly
11 impossible leading to increase likelihood of rapid infection spread⁴; and
12

13 Whereas, Interventions that are designed to house, space and treat homeless persons to allow
14 for adequate ability for persons to socially distance and quarantine are first steps to begin
15 addressing this issue³; and
16

17 Whereas, Implementing housing-first interventions for homeless persons improves their quality
18 of life while also reducing ineffective public service spending⁵; and
19

20 Whereas, Healthcare spending has been found to be up to 3.3 times higher for homeless
21 persons than the national average of Medicaid spending per enrollee⁶, and the homelessness is
22 linked to greater usage of acute hospital services⁵; and
23

24 Whereas Involvement in drugs and untreated mental illness, compounded with other negative
25 life events, are social determinants that often lead to homelessness⁵; and
26

27 Whereas, Current AMA policy has not made any measurable changes within this public health
28 crisis by virtue of being too broad, therefore necessary changes must be added to make
29 specific, measurable and worthwhile changes to advocate for the health of individuals
30 experiencing homelessness in the United States; therefore be it
31

32 RESOLVED, That our American Medical Association support training to understand the needs
33 of housing insecure individuals for those who encounter this vulnerable population through their
34 professional duties (New HOD Policy); and be it further
35

36 RESOLVED, That our AMA support the establishment of multidisciplinary mobile homeless
37 outreach teams trained in issues specific to housing insecure individuals (New HOD Policy); and
38 be it further

1 RESOLVED, That our AMA reaffirm existing policies H-160.903, “Eradicating Homelessness,”
2 and H-345.975, “Maintaining Mental Health Services by States” (Reaffirm HOD Policy); and be it
3 further
4

5 RESOLVED, That our AMA reaffirm existing policy H-160.978, “The Mentally Ill Homeless,” with
6 a title change “Housing Insecure Individuals with Mental Illness”. (Reaffirm HOD Policy)

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

Received: 04/08/22

References:

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing

homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19;

The Mentally Ill Homeless H-160.978

(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19;

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

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

Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem H-440.938

(1) Testing for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the U.S. Public Health Service.

(2) Testing for HIV infection should be routinely performed on all persons with active tuberculosis.

(3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical

management and epidemiologic surveillance.

(4) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved.

(5) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered.

(6) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely.

(7) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community. Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations.

(8) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service guidelines for preventing the nosocomial transmission of tuberculosis.

(9) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment.

(10) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis.

(11) Routinely, drug susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible.

(12) A program of directly observed therapy for tuberculosis should be implemented when patient compliance is a problem.

(13) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis.

(14) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines.

(15) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant women.

(16) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report.

(17) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains.

Citation: (BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-22)

Introduced by: Obesity Medicine Association, Colorado, Arizona

Subject: Creation of an Obesity Task Force

Referred to: Reference Committee D

1 Whereas, Obesity has been recognized by our AMA as a disease¹; and
2
3 Whereas, Obesity is preventable and effective treatments are available; and
4
5 Whereas, A top strategic objective of our AMA is to improve health outcomes with regards to
6 type two diabetes and hypertension;² and
7
8 Whereas, Obesity rates continue to increase and obesity (BMI 30 or more) currently affects 40%
9 of Americans and overweight/pre-obesity (BMI 25 - 29.9) affects 32% of Americans³; and
10
11 Whereas, Obesity is currently estimated to kill 320,000 Americans and cost 1.72 trillion dollars
12 (9.3% of GDP) per year⁴; and
13
14 Whereas, People with obesity are at a higher risk for suffering severe complications from
15 COVID-19 including ICU admissions, mechanical ventilation and death⁵; and
16
17 Whereas, "The prevalence of adult obesity and severe obesity will continue to increase
18 nationwide, with large disparities across states and demographic subgroups;"⁶ and
19
20 Whereas, Obesity rates in children ages 2-19 continue to increase and obesity is currently
21 estimated to affect 19% of children⁷; and
22
23 Whereas, The Framingham Heart Study estimated that excess body weight (including
24 overweight and obesity), accounted for approximately 26 percent of cases of hypertension in
25 men and 28 percent in women, and for approximately 23 percent of cases of coronary heart
26 disease in men and 15 percent in women⁸; and
27
28 Whereas, While the Affordable Care Act requires payment of preventive health care services
29 rated by the United States Preventive Task Force Services (USPSTF) with an "A" or "B"
30 recommendation, and the USPSTF recommends obesity screening and counseling services

¹ AMA policy H-440.842

² <https://www.ama-assn.org/delivering-care/public-health/about-improving-health-outcomes>

³ Cheryl D. Fryar, et al. (September 2018). "Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2015–2016" (PDF). Health E-Stats. National Center for Health Statistics, Division of Health Interview Statistics. Retrieved December 26, 2018.

⁴ <https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB.pdf> accessed 11/14/2019

⁵ Kompaniyets L, Goodman AB, Belay B, et al. Body mass index and risk for COVID-19-related hospitalization, intensive care unit admission, invasive mechanical ventilation, and death - United States, March - December 2020. MMWR Morb Mortal Wkly Rep. 2021;70(10):355-361.

⁶ N Engl J Med 2019; 381:2440-2450. DOI: 10.1056/NEJMsa1909301

⁷ <https://www.cdc.gov/obesity/data/childhood.html> accessed 11/18/2019

⁸ <https://www.obesityaction.org/community/article-library/hypertension-and-obesity-how-weight-loss-affects-hypertension/> accessed 11/18/2019

1 (evidence grade “B”), 24 states currently have general exclusions for weight/obesity
2 management services and make no mention of obesity screening and counseling services.⁹
3 This represents discriminatory behavior, which is in direct contradiction to established AMA
4 policy: “Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions
5 for Essential Health Benefits Under the Affordable Care Act.”¹⁰; and
6

7 Whereas, Obesity disproportionately affects women and minorities^{11,12,13}; and
8

9 Whereas, According to the CDC Maternal morbidity and mortality rates are indirect measure of
10 the strength of our healthcare; and women with obesity are at increased risk for cardiac
11 dysfunction, proteinuria, sleep apnea, nonalcoholic fatty liver disease, gestational diabetes
12 mellitus, and preeclampsia¹⁴ and pre-pregnancy obesity is associated with infertility, stillbirth,
13 early termination of breastfeeding, postpartum anemia, and depression. Further, long-term risks
14 for the infants of women with obesity include an increased risk of metabolic syndrome and
15 childhood obesity;¹⁵ and
16

17 Whereas, In a nationally representative sample of US adults, the prevalence of diabetes
18 increases with increasing weight classes. Nearly one fourth of adults with diabetes have poor
19 glycemic control and nearly half of adults with diabetes have obesity, suggesting that weight
20 loss is an important intervention to reduce the impact of diabetes on the health care system¹⁶;
21 and
22

23 Whereas, It is estimated that the prevalence of diabetes will increase by 54% to more than 54.9
24 million Americans between 2015 and 2030; annual deaths attributed to diabetes will climb by
25 38% to 385,800; and total annual medical and societal costs related to diabetes will increase
26 53% to more than \$622 billion by 2030¹⁷; and
27

28 Whereas, Consistent with the AMA’s improving health outcomes strategic plan initiative, “The
29 best solution for turning around the diabetes epidemic is preventing prediabetes and its
30 progression to diabetes in the first place. Achieving such an outcome calls for addressing
31 underlying societal risk factors that can contribute to unhealthy lifestyles and would require a
32 “population-wide” approach that addresses health promotion, obesity prevention, and creates a
33 physical, cultural, and psychological environment that supports healthy living naturally. This
34 outcome could not be achieved by individual health providers and patients alone, but requires
35 integrated systems of care incentivized for desired health outcomes. It also would require a
36 political will for effective policies and commitment of the public at all levels”¹⁸; and
37

38 Whereas, In spite of AMA policy calling on our AMA to work with national specialty and state
39 medical societies to advocate for patient access to and physician payment for the full continuum
40 of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical,
41 psychosocial, nutritional, and surgical interventions), coverage of these services remains

⁹ <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

¹⁰ Resolution 814, i16 – H-185.925

¹¹ CDC, http://www.cdc.gov/nchs/data/hestat/obesity_adult_11_12/obesity_adult_11_12.htm accessed 11/14/2016

¹² https://www.cdc.gov/pcd/issues/2019/18_0579.htm accessed 3/10/2022

¹³ Flegal KM, Kruszon-Moran D, Carroll MD, Fryar CD, Ogden CL. Trends in Obesity Among Adults in the United States, 2005 to 2014. *JAMA*. 2016;315(21):2284-2291. doi:10.1001/jama.2016.6458

¹⁴ American College of Obstetricians and Gynecologists’ Committee on Practice Bulletins—Obstetrics. Obesity in Pregnancy: ACOG Practice Bulletin, Number 230. *Obstet Gynecol*. 2021 Jun 1;137(6):e128-e144.

¹⁵ Boney CM, Verma A, Tucker R, Vohr BR. Metabolic syndrome in childhood: association with birth weight, maternal obesity, and gestational diabetes mellitus. *Pediatrics* 2005; 115 : e290 – 6

¹⁶ <https://www.ncbi.nlm.nih.gov/pubmed/21128002> accessed 11/18/2019

¹⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278808/> accessed 3/10/2022

¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278808/>

1 inconsistent, with Medicare still not allowing payment for behavioral treatment outside of the
2 primary care setting, or for anti-obesity pharmacotherapy¹⁹; and

3
4 Whereas, While 85% of individuals affected by type 2 diabetes receive pharmacotherapy, only
5 ~2% receive obesity pharmacotherapy²⁰ and only ~1% receive metabolic and bariatric
6 surgery²¹, both modalities that can improve health outcomes including prediabetes, diabetes
7 and hypertension and deserve a broader multi-stakeholder strategy; and

8
9 Whereas, Simply telling patients affected by obesity to “eat less, move more,” has not worked
10 and has been shown not to result in long-term sustained weight loss over 85% of the time
11 because CNS pathways sense changes in weight and body energy stores and exert opposing
12 effects on energy balance to promote homeostasis^{22,23,24}; and

13
14 Whereas, A recent AMA report found that obesity education remains inadequate at medical
15 school and residency programs²⁵; and

16
17 Whereas, “Low levels of emotional rapport in primary care visits with patients with overweight
18 and obesity may weaken the patient-physician relationship, diminish patients’ adherence to
19 recommendations, and decrease the effectiveness of behavior change counseling,” leading to
20 increases in physician burnout²⁶; and

21
22 Whereas, Our AMA is in a position to influence public policies around obesity ranging from
23 public awareness and physician education to public policy around nutrition and insurance
24 coverage of evidence-based obesity prevention and treatment services; and

25
26 Whereas, In spite of the numerous policies our AMA has adopted regarding obesity, education
27 remains sparse²⁷, coverage for evidence-based services remains inconsistent, and current
28 efforts at prevention and treatment remain largely ineffective; and

29
30 Whereas, An Obesity Caucus, formed in 2015, has been growing and attracting multiple state
31 and specialty societies; and

32
33 Whereas, Our AMA has demonstrated that through creation of a task force, we can successfully
34 address health epidemics including the tobacco and opioid epidemics; therefore be it

35
36 RESOLVED, That our American Medical Association create an obesity task force to evaluate
37 and disseminate relevant scientific evidence to healthcare clinicians, other providers and the
38 public (Directive to Take Action); and be it further

¹⁹ Policy D-440.954, AMA a18

²⁰ Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: a comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. *Obesity* (Silver Spring). 2016; 24(9):1955–61.

²¹ <https://www.asmb.org>

²² Chaput JP et al. *Obes Rev*. 2012;13:681-691.

²³ NHLBI. 2012. www.nhlbi.gov/health/health-topics/topics/obe/causes#. Accessed May 23rd, 2017.

²⁴ Schwartz MW et al. *Diabetes*. 2003;52:232-238.

²⁵ CME report 3, AMA a-17

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3694993/> Accessed 11/19/2019

²⁷ Mastrocola MR, et al. *Int J Obes (Lond)*. 2019. (<https://www.ncbi.nlm.nih.gov/pubmed/31551484/?i=4&from=stanford%20fc#>) Accessed 11/21/2019

1 RESOLVED, That the obesity task force address issues including but not limited to:
2

- 3 ● Promotion of awareness amongst practicing physicians and trainees that obesity
4 is a treatable chronic disease along with evidence-based treatment options.
- 5 ● Advocacy efforts at the state and federal level to impact the disease obesity.
- 6 ● Health disparities, stigma and bias affecting people with obesity.
- 7 ● Lack of insurance coverage for evidence-based treatments including intensive
8 lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic
9 surgery.
- 10 ● Increasing obesity rates in children, adolescents and adults.
- 11 ● Drivers of obesity including lack of healthful food choices, over-exposure to
12 obesogenic foods and food marketing practices. (Directive to Take Action)

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

Received: 04/21/22

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842

Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Citation: (Res. 420, A-13)

Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925

1. Our AMA supports improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage.
2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage.
3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.

Citation: Res. 814, I-16;

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

BOT Rep. 11, I-06 Reaffirmation A-13 Appended: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14

Appended: Res. 201, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-22)

Introduced by: Oklahoma

Subject: School Resource Officer Violence De-Escalation Training and Certification

Referred to: Reference Committee D

1 Whereas, A school resource officer (SRO), by federal definition, is a career law enforcement
2 officer with sworn authority who is deployed by an employing police department or agency in a
3 community-oriented policing assignment to work in collaboration with one or more schools(1);
4 and

5
6 Whereas, National Association of School Resource Officers recommends that agencies select
7 officers carefully for SRO assignments and that officers receive at least 40 hours of specialized
8 training in school policing before being assigned(1); and

9
10 Whereas, The Oklahoma Association of School Resource Officers report most but not all SRO
11 in schools throughout Oklahoma receive this nationally-recognized, basic and advanced SRO
12 training(2); and

13
14 Whereas, Widespread protests against police brutality and racial injustice over several years
15 have spurred districts across the nation to debate whether to keep police officers in schools(3);
16 therefore be it

17
18 RESOLVED, That our American Medical Association highly recommend mandatory conflict
19 de-escalation training for all school resource officers (New HOD Policy); and be it further

20
21 RESOLVED, That our AMA actively advocate to the National Association of School Resource
22 Officers to develop a program for certification of School Resource Officers including but not
23 limited to violence de-escalation training requirements, expiration date, renewal continuing
24 education requirements and a revocation procedure in the rare event of misconduct. (Directive
25 to Take Action)

REFERENCES

1. <https://www.nasro.org/faq/>
2. <https://m.facebook.com/OklahomaAssociationOfSchoolResourceOfficers/>
3. <https://www.google.com/amp/s/oklahoman.com/article/5666711/okc-board-approves-2-million-contract-for-school-resource-officers/amp>

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

Received: 04/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-22)

Introduced by: Oklahoma
Subject: Tobacco Control
Referred to: Reference Committee D

1 Whereas, Tobacco remains the leading cause of preventable disease in America, killing more
2 than 480,000 Americans each year; and
3
4 Whereas, 16 million Americans are living with a tobacco-related disease; and
5
6 Whereas, The tobacco companies have conducted an organized conspiracy to commit fraud in
7 violation of the federal Racketeer Influenced and Corrupt Organization (RICO) Act; and
8
9 Whereas, 2020 should be the year that health of our citizens is prioritized over the tobacco
10 industry; and
11
12 Whereas, A smoke-free work environment should be afforded to all U.S. citizens; and
13
14 Whereas, Secondhand smoke is a serious health hazard causing, or making worse, many
15 diseases and conditions, including lung cancer, heart disease, stroke, and asthma; and
16
17 Whereas, The U.S. Surgeon General has concluded there is no safe level of exposure to
18 secondhand smoke; and
19
20 Whereas, Oklahoma is one of 22 states that has failed to pass comprehensive smoke-free laws;
21 and
22
23 Whereas, Many workplaces like the hospitality industry (i.e., restaurants, bars, and gaming
24 establishments) in Oklahoma are often exposed to secondhand smoke daily; and
25
26 Whereas, By making white-collar workplaces smoke free while allowing blue-collar workplaces
27 to continue to expose people to hazardous air, our current policies are widening inequalities in
28 health; and
29
30 Whereas, If 100% of workplaces were covered by smoke free policies, health disparities would
31 be significantly reduced; therefore be it
32
33 RESOLVED, That American Medical Association policy H-490.913, "Smoke-Free and Vape-
34 Free Environments and Workplaces," be amended by addition and deletion to read as follows:
35
36 On the issue of the health effects of environmental tobacco smoke (ETS), passive
37 smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA:
38 (1)(a) supports classification of ETS as a known human carcinogen, and (b) concludes
39 that passive smoke exposure is associated with increased risk of sudden infant death
40 syndrome and of cardiovascular disease, and (c) encourages physicians and medical

1 societies to take a leadership role in defending the health of the public from ETS risks
2 and from political assaults by the tobacco industry, and and (d) encourages the concept
3 of establishing smoke-free and vape-free campuses for business, labor, education, and
4 government, and (2) (a) honors companies and governmental workplaces that go
5 smoke-free and vape-free, and (b) will petition the Occupational Safety and Health
6 Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the
7 workplace, and will use active political means to encourage the Secretary of Labor to
8 swiftly promulgate an OSHA standard to protect American workers from the toxic effects
9 of ETS in the workplace, preferably by banning smoking and vaping in the workplace,
10 and (c) encourages state medical societies (in collaboration with other anti-tobacco
11 organizations) to support the introduction of local and state legislation that prohibits
12 smoking and vaping around the public entrances to buildings and in all indoor public
13 places, restaurants, bars, and workplaces, and and (d) will update draft model state
14 legislation to prohibit smoking and vaping in public places and businesses, which would
15 include language that would prohibit preemption of stronger local laws. (3) (a)
16 encourages state medical societies to: (i) support legislation for states and counties
17 mandating smoke-free and vape-free schools and eliminating smoking and vaping in
18 public places and businesses and on any public transportation, and (ii) enlist the aid of
19 county medical societies in local anti-smoking and anti-vaping campaigns, and and (iii)
20 through an advisory to state, county, and local medical societies, urge county medical
21 societies to join or to increase their commitment to local and state anti-smoking and anti-
22 vaping coalitions and to reach out to local chapters of national voluntary health agencies
23 to participate in the promotion of anti-smoking and anti-vaping control measures, and (b)
24 urges all restaurants, particularly fast food restaurants, and convenience stores to
25 immediately create a smoke-free and vape-free environment, and (c) strongly
26 encourages the owners of family-oriented theme parks to make their parks smoke-free
27 and vape-free for the greater enjoyment of all guests and to further promote their
28 commitment to a happy, healthy life style for children, and (d) encourages state or local
29 legislation or regulations that prohibit smoking and vaping in stadia and encourages
30 other ball clubs to follow the example of banning smoking in the interest of the health
31 and comfort of baseball fans as implemented by the owner and management of the
32 Oakland Athletics and others, and (e) urges eliminating cigarette, pipe and cigar
33 smoking and vaping in any indoor area where children live or play, or where another
34 person's health could be adversely affected through passive smoking inhalation, and (f)
35 urges state and county medical societies and local health professionals to be especially
36 prepared to alert communities to the possible role of the tobacco industry whenever a
37 petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become
38 directly involved in community tobacco control activities, and and (g) will report annually
39 to its membership about significant anti-smoking and anti-vaping efforts in the prohibition
40 of smoking and vaping in open and closed stadia, and (4) calls on corporate
41 headquarters of fast-food franchisers to require that one of the standards of operation of
42 such franchises be a no smoking and no vaping policy for such restaurants, and
43 endorses the passage of laws, ordinances and regulations that prohibit smoking and
44 vaping in fast-food restaurants and other entertainment and food outlets that target
45 children in their marketing efforts, and (5) advocates that all American hospitals ban
46 tobacco and supports working toward legislation and policies to promote a ban on
47 smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals,
48 health care institutions, retail health clinics, and educational institutions, including
49 medical schools, and (6) will work with the Department of Defense to explore ways to
50 encourage a smoke-free and vape-free environment in the military through the use of
51 mechanisms such as health education, smoking and vaping cessation programs, and
52 the elimination of discounted prices for tobacco products in military resale facilities, and

- 1 (7) ~~encourages and supports~~ collaborates with local and state medical societies and
 2 tobacco control coalitions to work with (a) Native American casino and tribal leadership
 3 to voluntarily prohibit smoking and vaping in their casinos, and (b) legislators and the
 4 gaming industry to support the prohibition of smoking and vaping in all casinos and
 5 gaming venues. (Modify Current HOD Policy)

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<https://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/>

<https://no-smoke.org/wp-content/uploads/pdf/BridgingtheGap-ExecutiveSummary.pdf>

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

Received: 04/26/22

RELEVANT AMA POLICY**Smoke-Free and Vape-Free Environments and Workplaces H-490.913**

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially

prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04; Modified: CSAPH Rep. 1, I-07; Reaffirmation I-14; Reaffirmation I-15; Modified: Res. 902, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-22)

Introduced by: Oklahoma
Subject: Lung Cancer Screening Awareness
Referred to: Reference Committee D

1 Whereas, Oklahoma health outcomes are poor and rank low on a yearly basis; and
2
3 Whereas, Lung cancer is the number one cause of cancer-related death in Oklahoma, U.S., and
4 the world, and is more deadly than the next major causes combined: Breast, prostate, colon(1),
5 and
6
7 Whereas, According to the American Lung Association State of Lung Cancer Report, most lung
8 cancer cases are diagnosed at later stages when the cancer has spread to other organs,
9 treatment options are less likely to be curative, and survival is lower(2); and
10
11 Whereas, The rationale for lung cancer screening is that it is prevalent, detectable, non-invasive
12 at an early stage, outcome depends on stage, and stage is a function of time(3); and
13
14 Whereas, Lung cancer screening with low-dose CT scans has been recommended for those at
15 high risk since 2013 but only 4.2 percent of those eligible were screened in 2018(2); and
16
17 Whereas, Lung cancer screening with low-dose CT scans has been shown to decrease
18 mortality by 20%(4); and
19
20 Whereas, 12.7% adults aged 55–80 years met the United States Preventive Services Task
21 Force (USPSTF) criteria for lung cancer screening. Among those meeting these criteria, only
22 12.5% reported they had received a CT scan to screen for lung cancer in the last 12 months(1);
23 and
24
25 Whereas, Oklahoma was one of 31 states that has improved access to screening by covering it
26 through its fee-for-service Medicaid program as of January 2019. The program used
27 recommended guidelines for determining eligibility but it requires prior authorization(2);
28 therefore be it
29
30 RESOLVED, That our American Medical Association empower the American public with
31 knowledge through an education campaign to raise awareness of lung cancer screening with
32 low-dose CT scans in high-risk patients to improve screening rates and decrease the leading
33 cause of cancer death in the United States. (Directive to Take Action)

REFERENCES:

- (1) https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
- (2) <https://www.lung.org/assets/documents/research/ALA-SOLC-2019-Key-Findings.pdf>
- (3) <https://www.ncbi.nlm.nih.gov/m/pubmed/22031728/>
- (4) <https://www.nejm.org/doi/full/10.1056/NEJMoa1911793>

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

Received: 04/26/22

Evidence-based review:

<https://www.nejm.org/doi/full/10.1056/NEJMoa1102873>

8/4/2011, NEJM

Screening with the use of low-dose CT reduces mortality from lung cancer. (Funded by the National Cancer Institute; National Lung Screening Trial ClinicalTrials.gov number, [NCT00047385](https://www.clinicaltrials.gov/ct2/show/study/NCT00047385).)

<https://www.nejm.org/doi/full/10.1056/NEJMoa1911793>

2/06/2020 NEJM

In this trial involving high-risk persons, lung-cancer mortality was significantly lower among those who underwent volume CT screening than among those who underwent no screening. There were low rates of follow-up procedures for results suggestive of lung cancer.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
2.28/2020 MMWR

What is already known about this topic?

The U.S. Preventive Services Task Force (USPSTF) recommends annual lung cancer screening for adults aged 55–80 years who have a ≥ 30 pack-year cigarette smoking history and currently smoke or have quit < 15 years ago.

What is added by this report?

In 10 states, one in eight persons aged 55–80 years met USPSTF criteria, and, among those meeting USPSTF criteria, only one in eight reported a lung cancer screening exam in the last 12 months.

What are the implications for public health practice?

Public health initiatives to prevent cigarette smoking, increase smoking cessation, and increase recommended lung cancer screening could help reduce lung cancer mortality.

<https://pubmed.ncbi.nlm.nih.gov/32001154/>

Clinical Lung Cancer, 5/2020

Lung cancer screening remains heavily underutilized despite guideline recommendation since 2013, insurance coverage, and its potential to prevent thousands of lung cancer deaths annually.

file:///C:/Users/wjenkins/Downloads/ritzwoller_2021_oj_210815_1633035210.98986.pdf

JAMA Network Open, 10/12/2021

This cohort study suggests that, in diverse health care systems, adopting the 2021 USPSTF recommendations will increase the number of women, racial and ethnic minority groups, and individuals with lower SES who are eligible for lung cancer screening, thus helping to minimize the barriers to screening access for individuals with high risk for lung cancer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-22)

Introduced by: Illinois

Subject: Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

Referred to: Reference Committee D

- 1 Whereas, Individuals with mental health illnesses are overrepresented in the criminal justice
2 system¹; and
3
- 4 Whereas, Researchers estimate that 7-10% of all police interactions involve mental health crisis
5 assistance²; and
6
- 7 Whereas, The number of violent incidents that occur during mental health-related calls might
8 have been mitigated with the assistance of medical professionals; and
9
- 10 Whereas, Police officers are not universally trained in mental health crisis control; and
11
- 12 Whereas, Many police departments have tried to address police mental health training through
13 crisis intervention team (CIT) models where police are trained in de-escalation tactics and
14 provided with resources to refer individuals to mental health services rather than criminal justice
15 services^{3,4}; and
16
- 17 Whereas, Researchers have demonstrated that even police officers trained in CIT models were
18 only able to recognize half as many cases of mental health illness as clinically trained graduate
19 students⁵; and
20
- 21 Whereas, Qualitative analysis of officers in the Chicago Police Department have demonstrated
22 that officers are frustrated with their inability to effect long-term change for people in mental
23 health-related calls due to the constraints of the current system⁶; and
24
- 25 Whereas, The Illinois Criminal Justice Information Authority found that nearly 70% of Illinois
26 police departments consider mental health issues as one of the top issues for their department³;
27 and
28
- 29 Whereas, The number of mental health-related police detentions and hospitalizations are
30 greatly reduced in mental health and police co-responder models compared to police-only
31 models^{4,7,8}; and
32
- 33 Whereas, The average cost per mental health crisis is lower in existing street triage models
34 compared to a police-only response^{4,9,10}; and
35
- 36 Whereas, Major cities including Chicago and New York City are launching co-responder
37 programs so that police officers are paired with a healthcare professional when responding to
38 mental health crisis calls; therefore be it

- 1 RESOLVED, That our American Medical Association support efforts to increase the use of
- 2 co-response (police and mental health worker) teams for non-violent mental health-related 911
- 3 calls. (New HOD Policy)

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

Received: 05/02/22

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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;

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

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

Mental Health Crisis Interventions H-345.972

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

Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21;
Reaffirmed: BOT Rep. 2, I-21;

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

Our AMA:

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

Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21;

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995

Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.

Citation: (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01;
Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-15)

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

1 Whereas, The World Health Organization estimates that direct damage to health (not including
2 costs of damage mediated by effects on agriculture, water, and sanitation) will reach \$2-4billion
3 per year by 2030¹⁰; and
4

5 Whereas, Across all climate-related risks, children, older adults, low-income communities,
6 outdoor workers, minoritized communities, and communities burdened by poor environmental
7 quality are disproportionately affected ¹¹⁻¹⁴; and
8

9 Whereas, '*Climate justice*' is a term used for framing global warming as an ethical and political
10 issue, rather than one that is purely environmental or physical in nature by relating the effects of
11 climate change to concepts of justice, particularly environmental justice and social justice and
12 by examining issues such as equality, human rights; collective rights, and the historical
13 responsibilities for climate change¹⁵; and
14

15 Whereas, To avoid the worst consequences of climate change by keeping global warming from
16 pre-industrial levels to 1.5 degrees Celsius (2.7 degrees Fahrenheit), as outlined by the
17 Intergovernmental Panel on Climate Change (IPCC) will require global greenhouse gas (GHG)
18 emissions to have peaked by 2020 and net zero carbon emissions by 2050 at the latest,
19 highlighting that we are in a "vanishing window of opportunity for meaningful action"^{16,17,18}; and
20

21 Whereas, Physicians are uniquely trusted messengers with a responsibility to advocate for
22 science-based policies to safeguard health in the face of any public health crisis¹⁹; and
23

24 Whereas, Our AMA House of Delegates has adopted multiple policies addressing climate
25 change (*H-135.919*, [H-135.938](#), *H-135.977*, *H-135.923*, *D-135.968*, *D-135.969*, *H-135.973*), but
26 these policies fall short of actively coordinating strategic physician advocacy and leadership on
27 the scale necessary for such a health crisis; and
28

29 Whereas, In the face of the existential threat that the climate crisis poses, these policies have
30 not been leveraged to fulfill our AMA's *Declaration of Professional Responsibility* which commit
31 our profession to "[earning] society's trust in the healing profession" by "[educating] the public
32 and polity about present and future threats to the health of humanity" and "[advocating] for
33 social, economic, educational, and political changes that ameliorate suffering and contribute to
34 human well-being" (*H-140.900*); therefore, be it
35

36 RESOLVED, That our American Medical Association declare climate change a public health
37 crisis that threatens the health and well-being of all individuals (Directive to Take Action); and be
38 it further
39

40 RESOLVED, That our AMA protect patients by advocating for policies that: (1) limit global
41 warming to no more than 1.5 degrees Celsius, (2) reduce US greenhouse gas emissions, and
42 (3) achieve a reduced-emissions economy (Directive to Take Action); and be it further
43

44 RESOLVED, That our AMA develop a strategic plan for how we will enact our climate change
45 policies including advocacy priorities and strategies to decarbonize physician practices and the
46 health sector with report back to the House of Delegates at the 2023 Annual Meeting. (Directive
47 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

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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

1 determinants of health demonstrate that a lack of medical insurance is significantly correlated
2 with decreased likelihood of voting. In a study on two major US cities demonstrating this trend, it
3 was found that individuals with any insurance had an overall voter participation of 24%,
4 compared to 3% in those that were uninsured¹⁷; and
5

6 Whereas, in 2010 the Patient Protection and Affordable Care Act was implemented to increase
7 the number of Americans with health insurance and substantially decrease healthcare
8 associated costs. In 2012, the supreme court declared that the expansion of Medicaid, one of
9 the goals of the Affordable Care Act, would be optional for individual states despite the provision
10 of funding for this expansion¹⁸; and
11

12 Whereas, Today there are 12 remaining states that have chosen not to expand Medicaid
13 despite overwhelming support for Medicaid expansion and the federal funding available to do
14 so. Many of these states have utilized gerrymandering as a means to modify the evidence of
15 public opinion and manipulate the voice of the people¹⁹; and
16

17 Whereas, Those without health insurance are more likely to support government healthcare
18 programs, yet in the 2016 presidential election, voter turnout for uninsured Americans was
19 34%²⁰; and
20

21 Whereas, almost 40% of the voting-eligible American population did not vote in 2015, with
22 significant gaps in voter turnout existing along racial, educational, and income-level lines, largely
23 attributable to voting restrictions and feelings of alienation from the government⁷; and
24

25 Whereas, The relationship between health and voter participation perpetuate inequities in
26 health, social, and economic policy, further worsening health disparities. Historical examples of
27 initiatives that increase civic participation and improve health include the women's suffrage
28 movement which led to an increase in funding for women's health programming and a decrease
29 in child mortality by eight to 15% . Another example exists in the removal of literacy tests in
30 1965, which expanded the number of Black voters, increasing government funding to areas with
31 larger Black populations and shifting voting patterns within these communities^{4,7,8,14,16, 21-24}; and
32

33 Whereas, Voting between the ages of 18-24 is associated with fewer risky health behaviors by
34 instilling a sense of self-efficacy and increasing social connectedness. Voting is also correlated
35 with fewer depressive symptoms in adulthood^{8,9}; and
36

37 Whereas, Individuals who vote as a form of civic participation self-report a better state of health
38 than those who do not vote as well as those who abstain from voting report a poorer state of
39 health^{19,23}; and
40

41 Whereas, Options for interventions that allow voter registration in clinical settings exist and have
42 been successful in registering patients to vote. In a community clinic model, 89% of those who
43 were eligible to vote were registered with clinic-based voter registration^{11-13, 21}; and
44

45 Whereas, Between 2006 and 2018, physicians voted approximately 14% less than the general
46 population²⁶; and
47

48 Whereas, Additional research must examine the multidimensional impact of promotion of voter
49 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

1 Whereas, The current AMA policy H-135.938 1) supports the findings of the Intergovernmental
2 Panel on Climate Change's fourth assessment report, 2) supports educating the medical
3 community on the health implications of climate change, 3) recognizes the importance of
4 physician involvement in climate policymaking, 4) encourages physicians to assist in educating
5 patients on environmental sustainability, and 5) supports research necessary for evidence-based
6 climate change policy decisions; and
7

8 Whereas, The current AMA policy H-135.938 lacks explicit statement of the importance of
9 physician assessment of environmental determinants of health faced by their patients; and,
10 Whereas, physician assessment of environmental determinants will improve patient outcomes
11 and prevent future development and exacerbation of disease, especially for patients from low-
12 income communities or communities of color; and
13

14 Whereas, Previous studies have shown great physician interest in environmental health, but a
15 lack of confidence in their ability to take an environmental history. Currently, there is no
16 systematic documentation of environmental risk factors in the medical record and environmental
17 factors are often not specifically investigated and highlighted as a cause of disease; and
18

19 Whereas, A survey study of 500 primary care physicians showed that only 27.8% correctly
20 recognized all health effects related to environmental exposures, and those who recognized the
21 importance of the environment were significantly more likely to have knowledge of environmental
22 risk factors related to respiratory disease. Less than one third of physicians provided educational
23 material about environmental and public health to their patients, and those who asked their
24 patients about environmental exposures were significantly more likely to believe that
25 environmental health history is a useful tool to prevent environmental health exposures; therefore
26 be it
27

28 RESOLVED, That our American Medical Association amend policy H-135.938, "Global Climate
29 Change and Human Health," by addition to read as follows:
30

31 Our AMA:

- 32 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth
33 assessment report and concurs with the scientific consensus that the Earth is
34 undergoing adverse global climate change and that anthropogenic contributions
35 are significant. These climate changes will create conditions that affect public
36 health, with disproportionate impacts on vulnerable populations, including children,
37 the elderly, and the poor.
- 38 2. Supports educating the medical community on the potential adverse public health
39 effects of global climate change and incorporating the health implications of climate
40 change into the spectrum of medical education, including topics such as population
41 displacement, heat waves and drought, flooding, infectious and vector-borne
42 diseases, and potable water supplies.
- 43 3. (a) Recognizes the importance of physician involvement in policymaking at the
44 state, national, and global level and supports efforts to search for novel,
45 comprehensive, and economically sensitive approaches to mitigating climate
46 change to protect the health of the public; and (b) recognizes that whatever the
47 etiology of global climate change, policymakers should work to reduce human
48 contributions to such changes.
- 49 4. Encourages physicians to assist in educating patients and the public on
50 environmentally sustainable practices, and to serve as role models for promoting
51 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: Modest - between \$1,000 - \$5,000

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

1 constituent state associations to support state legislation to bar the promotion of
2 alcoholic beverage consumption on school campuses and in advertising in school
3 publications.

4 (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue
5 advertising directed toward youth, such as promotions on high school and college
6 campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television
7 program content that depicts the irresponsible use of alcohol without showing its
8 adverse consequences (examples of such use include driving after drinking, drinking
9 while pregnant, or drinking to enhance performance or win social acceptance); (c)
10 supports continued warnings against the irresponsible use of alcohol and challenges
11 the liquor, beer, and wine trade groups to include in their advertising specific warnings
12 against driving after drinking; and (d) commends those automobile and alcoholic
13 beverage companies that have advertised against driving while under the influence
14 of alcohol. (Modify Current HOD Policy); and be it further
15

16 RESOLVED, That our AMA advocate for the implementation of pictorial health warnings on
17 alcoholic beverages. (Directive to Take Action)

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

Received: 05/11/22

Sources:

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16. Zahra D, Monk RL, Corder E. If You Drink Alcohol, THEN You Will Get Cancer: Investigating How Reasoning Accuracy Is Affected by Pictorially Presented Graphic Alcohol Warnings. *Alcohol*. 2015;50(5):608-616. doi:10.1093/alcalc/aggv029
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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 disabilities³⁵⁻
34 ³⁶; 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

1 developmental disabilities, it is too narrow in its definition of disability to address the lack of
2 training that contributes to salient health inequities for an extremely diverse demographic that
3 shares experiences of stigma and discrimination in all arenas of public life; therefore be it
4

5 RESOLVED, That, in order to address the shared healthcare barriers of people with disabilities
6 and the need for curricula in medical education on the care and treatment of people with a
7 range of disabilities, our American Medical Association amend by addition and deletion
8 H-90.968 "Medical Care of Persons with Developmental Disabilities" to include those with a
9 broad range of disabilities while retaining goals specific to the needs of those with
10 developmental disabilities:

11
12 Medical Care of Persons with ~~Developmental~~ Disabilities, H-90.968

13 1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of
14 complex functioning profiles in all persons with ~~developmental~~ disabilities including but
15 not limited to physical, sensory, developmental, intellectual, learning, and psychiatric
16 disabilities and chronic illnesses; (b) medical schools and graduate medical education
17 programs to acknowledge the benefits of education on how aspects in the social model
18 of disability (e.g. ableism) can impact the physical and mental health of persons with
19 ~~Developmental~~ ~~D~~isabilities; (c) medical schools and graduate medical education
20 programs to acknowledge the benefits of teaching about the nuances of uneven skill sets,
21 often found in the functioning profiles of persons with developmental disabilities, to
22 improve quality in clinical care; (d) education of physicians on how to provide and/or
23 advocate for ~~quality~~, developmentally appropriate and accessible medical, social and
24 living support for patients with ~~developmental~~ disabilities so as to improve health
25 outcomes; (e) medical schools and residency programs to encourage faculty and trainees
26 to appreciate the opportunities for exploring diagnostic and therapeutic challenges while
27 also accruing significant personal rewards when delivering care with professionalism to
28 persons with profound ~~developmental~~ disabilities and multiple co-morbid medical
29 conditions in any setting; (f) medical schools and graduate medical education programs
30 to establish and encourage enrollment in elective rotations for medical students and
31 residents at health care facilities specializing in care for the ~~developmentally~~ disabled;
32 and (g) cooperation among physicians, health & human services professionals, and a
33 wide variety of adults with ~~developmental~~ disabilities to implement priorities and quality
34 improvements for the care of persons with ~~developmental~~ disabilities.

35 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians
36 in the care of individuals with ~~intellectual disabilities/developmentally disabled individuals~~,
37 and to increase the reimbursement for the health care of these individuals; and (b)
38 insurance industry and government reimbursement that reflects the true cost of health
39 care of individuals with ~~intellectual disabilities/developmentally disabled individuals~~.

40 3. Our AMA entreats health care professionals, parents, and others participating in
41 decision-making to be guided by the following principles: (a) All people with
42 ~~developmental~~ disabilities, regardless of the degree of their disability, should have access
43 to appropriate and affordable medical and dental care throughout their lives; and (b) An
44 individual's medical condition and welfare must be the basis of any medical decision. Our
45 AMA advocates for the highest quality medical care for persons with profound
46 ~~developmental~~ disabilities; encourages support for health care facilities whose primary
47 mission is to meet the health care needs of persons with profound ~~developmental~~
48 disabilities; and informs physicians that when they are presented with an opportunity to
49 care for patients with profound ~~developmental~~ disabilities, that there are resources
50 available to them.

51 ~~4. Our AMA will continue to work with medical schools and their accrediting/licensing~~
52 ~~bodies to encourage disability related competencies/objectives in medical school~~

1 ~~curricula so that medical professionals are able to effectively communicate with patients~~
 2 ~~and colleagues with disabilities, and are able to provide the most clinically competent and~~
 3 ~~compassionate care for patients with disabilities.~~

4 4. Our AMA will collaborate with appropriate stakeholders to create a model general
 5 curriculum/objective that (a) incorporates critical disability studies; and (b) includes
 6 people with disabilities as patient instructors in formal training sessions and preclinical
 7 and clinical instruction.

8 5. Our AMA recognizes the importance of managing the health of children and adults with
 9 developmental and intellectual disabilities as a part of overall patient care for the entire
 10 community.

11 6. Our AMA supports efforts to educate physicians on health management of children
 12 and adults with intellectual and developmental disabilities, as well as the consequences
 13 of poor health management on mental and physical health for people with intellectual and
 14 developmental disabilities.

15 7. Our AMA encourages the Liaison Committee on Medical Education, Commission of
 16 Osteopathic College Accreditation, and allopathic and osteopathic medical schools to
 17 develop and implement a curriculum on the care and treatment of people with a range of
 18 developmental disabilities.

19 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and
 20 graduate medical education programs to develop and implement curriculum on providing
 21 appropriate and comprehensive health care to people with a range of developmental
 22 disabilities.

23 9. Our AMA encourages the Accreditation Council for Continuing Medical Education,
 24 specialty boards, and other continuing medical education providers to develop and
 25 implement continuing programs that focus on the care and treatment of people with a
 26 range of developmental disabilities.

27 10. Our AMA will advocate that the Health Resources and Services Administration
 28 include persons with ~~intellectual and developmental~~ disabilities (IDD) as a medically
 29 underserved population.

30 11. Specific to people with developmental and intellectual disabilities, a uniquely
 31 underserved population, our AMA encourages: (a) medical schools and graduate medical
 32 education programs to acknowledge the benefits of teaching about the nuances of
 33 uneven skill sets, often found in the functioning profiles of persons with developmental
 34 and intellectual disabilities, to improve quality in clinical education; (b) medical schools
 35 and graduate medical education programs to establish and encourage enrollment in
 36 elective rotations for medical students and residents at health care facilities specializing
 37 in care for individuals with developmental and intellectual disabilities; and (c) cooperation
 38 among physicians, health and human services professionals, and a wide variety of adults
 39 with intellectual and developmental disabilities to implement priorities and quality
 40 improvements for the care of persons with intellectual and developmental disabilities.

41 (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

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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 “concur[s] 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),

1 and “supports initiatives to promote environmental sustainability and other efforts to halt global
2 climate change” (H-135.923); and
3

4 Whereas, The AMA has committed to exploring environmentally sustainable practices for the
5 distribution of the *Journal of the American Medical Association* (D-135.968) and moving “in a
6 timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and
7 fiduciary duties, to end all financial investments or relationships (divestment) with companies
8 that generate the majority of their income from the exploration for, production of, transportation
9 of, or sale of fossil fuels” (D-135.969); and
10

11 Whereas, The AMA currently lacks the organizational capacity to engage in health-oriented
12 climate advocacy that meets the scale of the global climate crisis; therefore be it
13

14 RESOLVED, That our American Medical Association: (1) Declare climate change an urgent
15 public health emergency that threatens the health and well-being of all individuals; (2)
16 Aggressively advocate for prompt passage of legislation and policies that limit global warming to
17 no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social
18 impacts of climate change through rapid reduction in greenhouse gas emissions aimed at
19 carbon neutrality by 2050, rapid implementation and incentivization of clean energy solutions,
20 and significant investments in climate resilience through a climate justice lens; (3) Study
21 opportunities for local, state, and federal policy interventions and advocacy to proactively
22 respond to the emerging climate health crisis and advance climate justice with report back to the
23 House of Delegates; and (4) Consider the establishment of a longitudinal task force or
24 organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an
25 equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the
26 House of Delegates. (Directive to Take Action)

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

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

1 *Disclaimer: We acknowledge that not all persons who give birth are women or prefer the term*
2 *“mother”, and that the following applies to all individuals who may give birth, regardless of*
3 *gender.*

4
5 *Data Collection on Pregnancy While Incarcerated*
6

7 Whereas, Since the 1980’s females (those assigned female at birth) have been the fastest-
8 growing segment of the incarcerated population, and in 2019, there were 218,000 females
9 incarcerated in prisons and jails within the United States comprising about 10% of incarcerated
10 individuals¹⁻³; and
11

12 Whereas, Three out of four incarcerated females in the United States are of childbearing age
13 and already mothers, and up to 80% of incarcerated females report being heterosexually active
14 without consistent contraceptive methods prior to being arrested, and this can lead to being
15 pregnant before entering incarceration^{2,4}; and
16

17 Whereas, In 2016 a survey of 22 state prisons found 3.8% of new admissions were pregnant
18 people, and in a similar survey conducted at U.S. jails, 3% of admissions were pregnant people,
19 which suggest a national jail admission rate of pregnant people to be around 55,000 a year^{4,5};
20 and
21

22 Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people
23 despite the high frequency of pre-existing health conditions in incarcerated populations and the
24 established relationship between incarceration and exacerbation of pre-existing medical
25 conditions⁶⁻⁹; and
26

27 Whereas, State and federal Maternal Mortality Review Committees and the CDC’s surveillance
28 reports on maternal mortality and morbidity use data from surveillance of perinatal outcomes to
29 improve understanding of disparities among racial groups and inform the development of
30 policies and initiatives aimed at meeting the needs of high-risk populations, but data on
31 incarceration status is not included in this surveillance⁸⁻²⁰; and
32

33 Whereas, Quality improvement research can improve care for vulnerable populations, and data
34 from surveillance of perinatal outcomes and studies regarding the accessibility and quality of
35 healthcare available to pregnant incarcerated people would expand the current knowledge of
36 disparities within this particularly vulnerable group²¹⁻²⁴; and
37

38 Whereas, There are currently no standard methodologies or requirements for collecting data on
39 incarcerated pregnant people and, prior to 2016, had been no organized review of pregnancy
40 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

1 Whereas, The American College of Obstetricians and Gynecologists opposes the policy of
2 immediate separation of infants from pregnant persons postpartum, stating that people who give
3 birth while incarcerated should be allowed the maximum time for parent-infant bonding and
4 further that immediately separating infants from incarcerated parents for non-medical reasons is
5 unnecessary, punitive, and harmful⁴⁰; and
6

7 Whereas, Eleven states offer alternatives to immediate separation, such as prison nursery
8 programs, which is a living arrangement located within a correctional facility in which an
9 imprisoned parent and their infant can consistently co-reside with the parent as the primary
10 caregiver during some or all of the mother's sentence^{44,45}; and
11

12 Whereas, Alternatives to immediate separation, like prison nursery programs, have been shown
13 to potentially increase infant-parent attachment and bonding, reduce recidivism, and improve
14 parents' self-esteem and child rearing skills^{44,45}; and
15

16 Whereas, In May 2021, Minnesota became the first state to oppose the immediate separation of
17 infants from incarcerated pregnant people through passing the Healthy Start Act, which allowed
18 incarcerated pregnant people to be placed in community-based programs such as halfway
19 houses during the late term of their pregnancy and up to one year after⁴⁶; and
20

21 Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American
22 Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a
23 baby's life^{47,48}; and
24

25 *Breastfeeding in Incarceration* 26

27 Whereas, Breast milk has established benefits for the baby, including reduced risks of infection,
28 such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2
29 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established
30 benefits of breastfeeding and breast milk expression for the mother, including reduced risk of
31 breast and ovarian cancer, type 2 diabetes mellitus, and hypertension⁴⁷⁻⁵⁰; and
32

33 Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities,
34 increased brain development in children, and improved mother-child relationship⁵¹; and
35

36 Whereas, The cost of infant formula is up to \$1,500 per year; alternatively, feeding a baby with
37 pasteurized donor human milk costs an average of \$4.50 per ounce, and further, the cost of
38 healthcare in a breastfed baby's first year of life is, on average, \$331 less than a formula-fed
39 baby⁵²⁻⁵⁶; and
40

41 Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the
42 health of both the mother and infant⁵⁷; and
43

44 Whereas, A woman's right to breastfeed or express breast milk in any private or public location
45 is protected by law in all 50 states of the United States; however, for mothers in prison, there
46 are significant barriers to expressing and storing breast milk, such as requiring presence of a
47 prison guard, time restrictions, and insufficient equipment^{58,59}; and
48

49 Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while
50 incarcerated will decrease their milk supply, hindering their ability to directly breastfeed⁶⁰; and

1 Whereas, In 2017, the National Commission on Correctional Health Care called on correctional
2 facilities to support programs for incarcerated women to breastfeed their babies directly or pump
3 breast milk and store it for later delivery to the infant⁶¹; and

4 Whereas, The protections for incarcerated mothers to express milk may be established on a
5 state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington
6 have laws offering protections, although still with limitations^{58,62-67}; and

7
8 Whereas, Our AMA supports initiatives to promote early intervention for healthcare needs of
9 children with incarcerated parents (H-60.903) and has supported research on bonding programs
10 for women prisoners and their newborn children (H-430.990) since 1997, but does not oppose
11 the separation of infants and postpartum people; and

12
13 Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated
14 individuals (D-430.997, H-430.986, H-430.997) and has supported standards to improve the
15 safety of pregnant incarcerated people (H-420.957), and our AMA has policies in support of
16 breastfeeding (H-245.982), though these policies do not specify protecting an incarcerated
17 mother's right to express milk; therefore be it

18
19 RESOLVED, That our American Medical Association encourage research efforts to characterize
20 the health needs for pregnant inmates, including efforts that utilize data acquisition directly from
21 pregnant inmates (Directive to Take Action); and be it further

22
23 RESOLVED, That our AMA support legislation requiring all correctional facilities, including those
24 that are privately-owned, to collect and report pregnancy-related healthcare statistics with
25 transparency in the data collection process (Directive to Take Action); and be it further

26
27 RESOLVED, That our AMA oppose the immediate separation of infants from incarcerated
28 pregnant individuals post-partum; (Directive to Take Action) and be it further

29
30 RESOLVED, That our AMA support solutions, such as community-based programs, which allow
31 infants and incarcerated postpartum individuals to remain together (Directive to Take Action);
32 and be it further

33
34 RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

35
36 Bonding Programs for Women Prisoners and their Newborn Children H-430.990
37 Because there are insufficient data at this time to draw conclusions about the long-term
38 effects of prison nursery programs on mothers and their children, the AMA supports and
39 encourages further research on the impact of infant bonding programs on incarcerated
40 women and their children. However, since there are established benefits of breast milk
41 for infants and breast milk expression for mothers, the AMA advocates for policy and
42 legislation that extends the right to breastfeed and/or pump and store breast milk to
43 include incarcerated mothers. The AMA recognizes the prevalence of mental health and
44 substance abuse problems among incarcerated women and continues to support
45 access to appropriate services for women in prisons. The AMA recognizes that a large
46 majority of incarcerated females who may not have developed appropriate parenting
47 skills are mothers of children under the age of 18. The AMA encourages correctional
48 facilities to provide parenting skills and breastfeeding/breast pumping training to all
49 female inmates in preparation for their release from prison and return to their children.
50 The AMA supports and encourages further investigation into the long-term effects of
51 prison nurseries on mothers and their children. (Modify Current HOD Policy)

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

Received: 05/11/22

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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

1 Whereas, An August 2021 analysis of 170 countries over the time period from 1990 to 2019
2 published in *Health Affairs* indicated that democratic quality and universal health coverage have
3 a statistically significant positive association, with free and fair elections identified as having the
4 strongest association with higher universal health coverage²¹; and
5

6 Whereas, A 2020 *BMJ* study of 17 countries found that decreases in democratic traits, including
7 free and fair elections, freedom of expression, freedom of civil and political association, between
8 2000 and 2010 were associated with lower life expectancy, reduced progress toward universal
9 health coverage, and increased out-of-pocket spending on healthcare²²; and
10

11 Whereas, The annual Freedom House reports, which rate the political and civil rights of
12 countries around the globe, have tracked a steady decline in multiple dimensions of democracy
13 in the United States from 2010 to 2020²³⁻²⁵; and
14

15 Whereas, From November 2020 to January 2021, multiple key government officials attempted
16 to subvert the results of the 2020 presidential election through a variety of mechanisms²⁶⁻³⁰; and
17

18 Whereas, During the counting of electoral votes on January 6-7, 2021, hundreds of
19 Representatives and Senators in Congress voted to reject electoral votes from key states in an
20 attempt which, if it had been successful, would have overturned the results of the 2020
21 presidential election³¹⁻³³; and
22

23 Whereas, Multiple state legislatures have since passed laws that provide unprecedented control
24 over state and local elections and could permit those legislatures to subvert election results³⁴⁻³⁷;
25 and
26

27 Whereas, These antidemocratic trends in the United States directly threaten the ability of
28 physicians and their patients to make their voices heard, thereby depriving them of a key
29 avenue to maximize their health and well-being; therefore be it
30

31 RESOLVED, That our American Medical Association unequivocally support the democratic
32 process, wherein representatives are regularly chosen through free and fair elections, as
33 essential for maximizing the health and well-being of all Americans (New HOD Policy); and be it
34 further
35

36 RESOLVED, That our AMA strongly oppose attempts to subvert the democratic process
37 (Directive to Take Action); and be it further
38

39 RESOLVED, That our AMA assert that every candidate for political office and every officeholder
40 in the public trust must support the democratic process and never take steps or support steps
41 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

1 educational materials, but do not address inclusion in medical curricula or specify how
2 physicians should be reimbursed for such efforts; and
3

4 Whereas, Physicians should be incentivized to provide firearm safety counseling for patients
5 through a combination of education and appropriate compensation for their time and efforts,
6 contributing to reduced morbidity and mortality from firearms; therefore be it
7

8 RESOLVED, That our American Medical Association support the inclusion of gun violence
9 epidemiology and evidence-based firearm-related injury prevention education in medical school
10 curricula (Directive to Take Action); and be it further
11

12 RESOLVED, That our AMA amend Policy H-145.976, "Firearm Safety Counseling in Physician-
13 Led Health Care Teams," by addition to read as follows:
14

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

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

23 2. Our AMA will work with appropriate stakeholders to develop state-specific guidance
24 for physicians on how to counsel patients to reduce their risk for firearm-related injury or
25 death, including guidance on when and how to ask sensitive questions about firearm
26 ownership, access, and use, and clarification on the circumstances under which
27 physicians are permitted or may be required to disclose the content of such
28 conversations to family members, law enforcement, or other third parties.

29 3. Our AMA will support the development of reimbursement structures that incentivize
30 physicians to counsel patients on firearm-related injury risk and prevention. (Modify
31 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