

## **Reference Committee D**

### **BOT Report(s)**

- 15 Addressing Public Health Disinformation

### **CSAPH Report(s)**

- 01 Council on Science and Public Health Sunset Review of 2012 HOD Policies
- 02 Transformation of Rural Community Public Health Systems

### **Resolution(s)**

- 401 Air Quality and the Protection of Citizen Health
- 402 Support for Impairment Research
- 403 Addressing Maternal Discrimination and Support for Flexible Family Leave
- 404 Weapons in Correctional Healthcare Facilities
- 405 Universal Childcare and Preschool
- 406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position
- 407 Study of Best Practices for Acute Care of Patients in the Custody of the Law
- 408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement
- 409 Increasing HPV Vaccination Rates in Rural Communities
- 410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention
- 411 Anonymous Prescribing Option for Expedited Partner Therapy
- 412 Advocating for the Amendment of Chronic Nuisance Ordinances
- 413 Expansion on Comprehensive Sexual Health Education
- 414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
- 415 Creation of an Obesity Task Force
- 416 School Resource Officer Violence De-Escalation Training and Certification
- 417 Tobacco Control
- 418 Lung Cancer Screening Awareness
- 419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

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

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### 1 INTRODUCTION

2  
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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.<sup>1</sup> 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.<sup>2,3,4</sup> 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.<sup>5,6,7,8</sup> Health professionals have been

involved in disseminating health-related disinformation, long before the COVID-19 pandemic, this includes promoting vaccine skepticism<sup>9,10</sup> and dangerous anti-cancer treatments.<sup>11</sup>

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

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

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

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

## PROFESSIONAL RESPONSIBILITY OF HEALTH PROFESSIONALS

### *Ethical Obligations*

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

Finally, it has been suggested that health professionals also have an ethical obligation to correct 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.<sup>20</sup> 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.<sup>21</sup>

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.<sup>22</sup>

#### 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.<sup>23,24</sup> 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.<sup>25</sup> In 2018, the top three professions in  
27 the Gallup poll for honesty and ethics were nurses, medical doctors, and pharmacists.<sup>26</sup> 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.<sup>27,28</sup> 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.<sup>29</sup>

## 1 IMPACT OF DISINFORMATION

### 3 *Impact on Patients and the Public*

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.<sup>30</sup> 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).

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.<sup>31</sup>

### 19 *Impact on Minoritized Communities*

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.<sup>32</sup> 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.<sup>33,34</sup> These beliefs may be intergenerational and are  
27 reinforced by the multitude of injustices faced by minoritized communities in health care.<sup>35,36</sup> 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.

### 31 *Impact on the Health Profession*

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.<sup>37</sup> But it also corroded trust in health professionals which gave  
37 way to targeted harassment campaigns of those following the science.<sup>38</sup>

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.<sup>39</sup> But when  
42 health professionals engage in actively spreading disinformation, there may be an overall corrosion  
43 of trust in health professionals.

### 45 *Economic Impact*

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.<sup>40</sup> 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.<sup>41</sup> In 2019,

1 Clark County Public Health, in Washington state, spent nearly \$865,000 responding to a measles  
2 outbreak.<sup>42</sup>  
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.<sup>46</sup> Further, misinformation and disinformation has caused between \$50 and \$300 million  
7 worth of total harm every day since May 2021.<sup>46</sup> 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.<sup>43</sup> 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.<sup>44,45,46</sup> 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.<sup>47</sup>  
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.<sup>48</sup> 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.<sup>49</sup>  
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.<sup>50</sup> 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.<sup>51</sup> 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.<sup>52</sup>  
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

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

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

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

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

### *Traditional Media and Paywalls*

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

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

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



### *Peer-Reviewed Journals and Preprints*

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

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

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

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

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

### *Incentives for Spreading Disinformation*

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

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

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

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

Beyond the indirect routes of monetization, there are also instances of credentialed health professionals using disinformation to drive patients towards their medical practices. For example, one group currently under investigation by the House Select Subcommittee on the Coronavirus Crisis is believed to be charging upwards of \$700 per patient for telehealth consults which were advertised to be with health professionals more likely to prescribe controversial, medications not authorized or approved to prevent or treat COVID-19.<sup>69</sup> The group is estimated to have generated more than \$6.7 million in a 3-month period in 2021.

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

## AUTHORITY OF LICENSING AND CREDENTIALING BOARDS

### *Authority of Licensing Boards*

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

### *Limitations to Board Authority*

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

### *First Amendment Considerations*

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

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

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

## ACTIONS TAKEN BY HEALTH PROFESSIONAL BOARDS

### *Federation of State Medical Boards*

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

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

#### *American Board of Medical Specialties*

In 2021, the American Board of Medical Specialties (ABMS) released a statement stating that the spread of misinformation is harmful to public health, is unethical and unprofessional, and may threaten certification by an ABMS Member Board.<sup>82</sup> Further, the American Board of Emergency Medicine<sup>83</sup>, the American Board of Pathology<sup>84</sup> and a joint statement by the American Boards of Family Medicine, Internal Medicine and Pediatrics<sup>85</sup> have stated that health professionals who are certified by specialty boards and spread disinformation place their certifications at risk.

#### *National Council of State Boards of Nursing*

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

#### *Pharmacy Boards*

The American Pharmacists Association as well as various state boards have noted that inappropriately prescribing or dispensing medications that are not approved to prevent or treat COVID-19 could be considered unethical and unprofessional conduct and may violate board rules.<sup>87,88,89,90</sup>

### LEGISLATIVE EFFORTS SURROUNDING DISINFORMATION

#### *Federal Efforts*

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

## *State Efforts*

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

## AMA POLICY AND ACTIONS TO ADDRESS DISINFORMATION

### *Existing AMA Policy*

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

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

### *The AMA as a Public Trust*

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

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

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

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

#### *Council on Ethical and Judicial Affairs and AMA membership*

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

#### CONCLUSION

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.

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,

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 &amp; Public Health Disinformation

Goal	Objectives/Tactics
Maintain AMA as a trusted source of evidence-based information for physicians and patients.	<ul style="list-style-type: none"> <li>• Provide evidence-based information to physicians.</li> <li>• Undertake public campaigns (like the COVID Collaborative on vaccines) in areas where disinformation is causing patients harm.</li> <li>• Educate health professionals and the public on how to recognize disinformation as well as how it spreads.</li> <li>• Continue to use the AMA's voice to speak out against the spread of health-related disinformation being spread by health professionals.</li> <li>• Maintain that CEJA has the authority to revoke AMA membership for those physicians spreading health-related disinformation.</li> </ul>
Ensure that evidence-based information is accessible.	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Discourage the dissemination of results of biomedical research unless they have received critical review by others in the scientific community.</li> </ul>
Address disinformation disseminated by health professionals via social media platforms.	<ul style="list-style-type: none"> <li>• Encourage health professionals' usage of social media platforms with robust disinformation policies in place.</li> <li>• 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</li> <li>• Consider the role of health professional societies in serving as appropriate fact-checking entities.</li> </ul>
Address the monetization of spreading disinformation on social media platforms.	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Health professionals should be responsible for representations of their professional recommendations in publications.</li> <li>• 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.</li> </ul>

<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"> <li>• Advocate for licensing boards to have authority to discipline health professionals spreading health-related disinformation.</li> <li>• 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.</li> <li>• Expedite timelines to process complaints in the domain of public health disinformation during public health emergencies.</li> </ul>
<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"> <li>• 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.</li> <li>• 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.</li> </ul>
<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"> <li>• 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.</li> <li>• Encourages medical specialty boards to work with social media platforms to verify and elevate credible sources of health information.</li> </ul>
<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"> <li>• Partner with community groups and other local organizations to prevent and address health disinformation.</li> </ul>

## 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

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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
<a href="#">D-100.971</a>	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.
<a href="#">D-115.990</a>	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.
<a href="#">D-120.950</a>	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.
<a href="#">D-130.974</a>	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 <del>Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland</del>	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.

		Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency. (Sub. Res. 803, I-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12)	
<a href="#">D-135.977</a>	Synthetic Gasification	Our AMA <del>supports</del> <del>will encourage</del> the study of the health effects of clean coal technologies including synthetic gasification plants. (Res. 514, A-12)	Retain as amended and change to H-policy.
<a href="#">D-425.992</a>	Recommendations by the USPSTF	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. (Res. 517, A-12)	Rescind, accomplished. These screenings are also addressed by Policy H-525.993, "Screening Mammography," and Policy H-425.980, "Screening and Early Detection of Prostate Cancer." Existing policy also addresses physician engagement in expert panels (See. H-410.955 and H-410.967 included below).
<a href="#">D-440.938</a>	Triclosan Antimicrobials	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. (Res. 513, A-12)	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,

<a href="#">D-440.999</a>	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.
<a href="#">D-470.993</a>	Government to Support Community Exercise Venues	Our AMA <del>will</del> 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.
<a href="#">D-480.977</a>	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.
<a href="#">D-95.978</a>	Public Service Announcements to Educate Children and Adults to Never to Use Medications Prescribed to Other Individuals	Our AMA <del>will</del> 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.
<a href="#">H-100.961</a>	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><del>(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.</del></p> <p><del>(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.</del></p> <p><del>(9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent</del></p>	
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		<p><del>forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.</del></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>	
<a href="#">H-120.950</a>	Change DEA Procedures in Partial Filling of Schedule II Prescriptions	<p>Our AMA <del>supports changes to requests that the federal Drug Enforcement Administration's change its</del> 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>
<a href="#">H-120.973</a>	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>	Retain as amended with change in title.
<a href="#">H-135.932</a>	Light Pollution: Adverse Health Effects of Nighttime Lighting	<p>Our AMA:</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.</li> <li>4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.</li> </ol> <p>(CSAPH Rep. 4, A-12)</p>	Retain, still relevant.

<a href="#">H-135.937</a>	Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings	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.  (Res. 516, A-09; Reaffirmed: CSAPH Rep. 4, A-12)	Retain, as amended still relevant.
<a href="#">H-135.959</a>	Eliminating Lead, Mercury and Benzene from Common Household Products	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.  (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)	Retain; still relevant.
<a href="#">H-140.855</a>	Gene Patents and Accessibility of Gene Testing	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.  (Res. 526, A-10; Modified in lieu of Res. 504, A-12)	Retain; still relevant.
<a href="#">H-150.935</a>	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	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.	Retain; still relevant.

		(Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)	
<a href="#">H-170.961</a>	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.
<a href="#">H-170.999</a>	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
<a href="#">H-245.968</a>	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.
<a href="#">H-250.988</a>	Low Cost Drugs to <del>Poor</del> <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 <del>poor</del> <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.”
<a href="#">H-410.955</a>	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.
<a href="#">H-410.960</a>	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.



<a href="#">H-410.967</a>	<del>Guide to Clinical Preventive Services</del>	<p>The AMA: (1) recommends the USPSTF <del>guidelines</del> <del>Guide to Clinical Preventive Services</del> to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. <del>USPSTF recommendations</del> <del>The Guide</del> 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>
<a href="#">H-420.960</a>	Effects of Work on Pregnancy	<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 <del>people</del> <del>women</del>; (4) encourages employers to accommodate <del>women's</del> increased physical requirements <del>of pregnant people</del> <del>during pregnancy</del>; 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>
<a href="#">H-430.994</a>	Prison-Based Treatment Programs for Drug Abuse	<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 <a href="#">H-430.987</a>, “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”
<a href="#">H-430.997</a>	Standards of Care for Inmates of Correctional Facilities	Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance <del>use disorder</del> <del>misuse</del> 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.
<a href="#">H-440.844</a>	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.
<a href="#">H-440.848</a>	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.
<a href="#">H-440.849</a>	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 <del>Adult and Influenza Vaccine</del> <u>Adult</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.

		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. (CSAPH Rep. 5, I-12)	
<a href="#">H-440.852</a>	Smallpox: A Scientific Update	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.  (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)	Retain; still relevant.
<a href="#">H-440.872</a>	HPV Vaccine and Cervical Cancer Prevention Worldwide	1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.  (Res. 503, A-07; Appended: Res. 6, A-12)	Retain; still relevant.
<a href="#">H-440.889</a>	Smallpox: A Scientific Update	Our AMA strongly supports the <del>June 20, 2002</del> , Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data.  (CSA Rep. 2, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain with amendments; ACIP recommendations have been updated.

<a href="#">H-440.921</a>	Pneumococcal Vaccination	Our AMA encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations, <del>for those at increased risk of serious pneumococcal infection and for all persons age 65 and over.</del> (Res. 512, A-94; Reaffirmed: Res. 515, I-01; Reaffirmed: Res. 520, A-02; Modified: CSAPH Rep. 1, A-12)	Retain with amendment should ACIP recommendations evolve based on the evidence.
<a href="#">H-445.995</a>	Responses to News Reports and Articles	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. (Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07; Reaffirmed: Res. 601, A-12)	Retain; still relevant.
<a href="#">H-460.905</a>	Clinical Application of Next Generation Genomic Sequencing	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. (CSAPH Rep. 4, I-12)	Retain; still relevant.
<a href="#">H-470.975</a>	Mandatory Physical Education	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.	Retain; still relevant.

		(Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07; Modified: BOT Rep. 21, A-12)	
<a href="#">H-470.989</a>	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
<a href="#">H-470.990</a>	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
<a href="#">H-470.996</a>	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
<a href="#">H-480.958</a>	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 <del>as of June 2012</del>, 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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		research developments in food biotechnology. (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. (CSA Rep. 10, I-00; Modified: CSAPH Rep. 1, A-10; Modified: <u>CASSAPH</u> Rep. 2, A-12)	
<a href="#">H-480.964</a>	Alternative Medicine	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. (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02; Modified: CSAPH Rep. 1, A-12)	Retain; still relevant.
<a href="#">H-485.998</a>	Television Commercials Aimed at Childre	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)	Retain; still relevant.
<a href="#">H-495.974</a>	Tax Incentives and Films Depicting Tobacco	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. (Res. 417, A-12)	Retain; still relevant.
<a href="#">H-495.981</a>	Light and Low-Tar Cigarettes	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: (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. (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-	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>	
<a href="#">H-515.959</a>	Reduction of Online Bullying	<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>	Retain; still relevant
<a href="#">H-525.984</a>	Breast Implants	<p>Our AMA: (1) supports that <u>individuals</u> <del>women</del> 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>	Retain as amended; to include gender-neutral language.



		(CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12)	
<a href="#">H-55.974</a>	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.
<a href="#">H-60.927</a>	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
<a href="#">H-60.943</a>	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>	
<a href="#">H-60.991</a>	Providing Medical Services through School-Based Health Programs	<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>	Retain; still relevant.

		<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>	
<a href="#">H-65.973</a>	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.
<a href="#">H-85.961</a>	Accuracy, Importance, and Application of	Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and	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

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## INTRODUCTION

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

## BACKGROUND

More than 65 million people living in the United States reside in rural jurisdictions.<sup>1</sup> 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.<sup>2,3</sup> Data from the Centers for Disease Control and Prevention (CDC) demonstrate 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.<sup>3</sup> 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.

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

Furthermore, issues related to rural health care have recently been studied by other AMA councils and will not be the focus of this report. Report 3 of the Council on Medical Education, “Rural Health Physician Workforce Disparities” was adopted as amended by the House of Delegates in November of 2021. The report recognized the need for a multifaceted approach to address the gap of rural health services and noted that the AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation’s underserved areas, including strategies to increase rural students’ exposure to careers in medicine to help expand rural physician pathways. Report 9 of the Council on Medical Services, “Addressing Payment and 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.”<sup>4</sup> These four factors have produced “an intergenerational cycle” resulting in widening  
30 gaps between rural America and the rest of the country.<sup>4</sup>

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.<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup> 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.<sup>7</sup> 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.<sup>7</sup>

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

#### *Access to Health Care*

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

### HEALTH DEPARTMENT STRUCTURE AND FUNCTIONS

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.<sup>1</sup> Rural LHDs, similar to their urban counterparts, 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.<sup>13</sup> 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.<sup>14</sup> 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).

#### *Leadership and Workforce*

Effective public health practice requires a well-prepared, multi-disciplinary workforce that is equipped to meet the needs of the community being served.<sup>15</sup> The Public Health Accreditation Board standards call for the development of a “sufficient number of qualified public health workers” and a competent workforce through assessment of staff competencies, individual training and professional development, and a supportive work environment. Building a strong public health workforce pipeline was also identified as a need in Public Health 3.0 with a focus on leadership and management skills in systems thinking and coalition building.<sup>16</sup>

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



1 rural populations.<sup>17</sup> Small, rural LHDs often have fewer staff than their urban counterparts.<sup>1</sup> 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.<sup>18</sup> 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.<sup>18</sup>

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.<sup>19</sup> Salary, lack of  
12 opportunity for advancement, and workplace environment were the top three reasons for leaving.<sup>19</sup>

### 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.<sup>20</sup> Rural LHDs are more reliant on federal, state, and clinical revenues as compared to their  
19 urban counterparts.<sup>1,17</sup> The predictability and stability of public health financing poses a challenge  
20 for rural LHDs.<sup>2</sup> 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.<sup>1</sup> 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.<sup>21</sup> Without meaningful growth in the  
25 resources available, it is challenging for local governments to meaningfully invest in public  
26 programs.<sup>1</sup>

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.<sup>17</sup> LHDs  
30 experienced decreases in clinical revenue between 2010 and 2016.<sup>2</sup> Urban LHDs provided fewer  
31 primary care services in 2016; rural LHDs provided more mental health and substance use disorder  
32 services.<sup>2</sup> Overall, rural LHDs generate more revenue from the Centers for Medicare and Medicaid  
33 Services and clinical services than their urban counterparts.<sup>2</sup>

### 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.<sup>22</sup> 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

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

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

### *Rural Public Health Networks*

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

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

## RURAL PUBLIC HEALTH OPPORTUNITIES

### *Cross Jurisdictional Sharing*

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

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

1 while maintaining two distinct LHDs.<sup>28</sup> 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.<sup>28</sup> 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.<sup>28</sup> 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.<sup>28</sup>

#### 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.<sup>14</sup> 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.<sup>14</sup> Anecdotal evidence  
18 suggests that technology has allowed LHDs to maintain and expand the reach and scope of the  
19 services they provide.<sup>14</sup> 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.<sup>29</sup>

#### 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.<sup>30</sup> NACCHO has created a guide to share recommendations and stories from the field  
29 about developing and maintaining partnerships in rural communities.<sup>30</sup>

#### 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.<sup>12</sup> 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.<sup>12</sup>  
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

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

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

Whereas, Emission compliance is tested only every 30 months<sup>5</sup> and there is a history of violations to EPA guidelines<sup>6</sup>; and

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

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

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

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

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

Received: 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](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](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

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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

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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;<sup>1</sup> 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;<sup>1</sup> 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;<sup>2</sup> 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 ;<sup>3</sup> 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;<sup>1</sup> 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;<sup>4</sup> and  
24

25 Whereas, Homeschooling rates have more than tripled during the pandemic due to educational  
26 needs and health concerns;<sup>6</sup> 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;<sup>7</sup> 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;<sup>7</sup>  
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

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

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

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

RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of 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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## 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

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Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being introduced into some Mental Health Units in federal correctional facilities in 2021; and

Whereas, Physicians in federal correctional healthcare settings who are employed by the Federal Bureau of Prisons are considered law enforcement officers; and

Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and

Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents of serious workplace violence (requiring days off work) are four times more common in healthcare settings than in private industry, so an intentional plan and response to reduce workplace violence is indicated (OSHA, 2015); and

Whereas, The American Psychiatric Association does not support the use of weapons as a clinical response in the management of patient behavioral dyscontrol in emergency room and inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA, 2018); and

Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These clinical approaches will typically involve psychological interpersonal interventions and when less restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion, and physical or mechanical restraint, following guidelines issued by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and

Whereas, The National Commission on Correctional Health Care supports the active prevention of violence through nonphysical methods to prevent and/or control disruptive behaviors including a balanced biopsychosocial approach (NCCHC, 2013); and

Whereas, Our *AMA Code of Ethics* notes "Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm" (AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes "Individual physicians who provide care under court order should: Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control."

(AMA Code of Ethics Opinion 9.7.2); and

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

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

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

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

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

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

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

Received: 04/05/22

**References:**

- Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP; Expert Consensus Panel for Behavioral Emergencies 2005. The expert consensus guideline series. Treatment of behavioral emergencies 2005. J Psychiatr Pract. 2005 Nov;11 Suppl 1:5-108; quiz 110-2. PubMed PMID: 16319571. <https://pubmed.ncbi.nlm.nih.gov/11500996/>
- 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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- 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

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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-kindergarten<sup>1</sup>; and  
3

4 Whereas, The COVID-19 pandemic caused a sharp decline in preschool enrollment, quality  
5 standards, teacher qualifications, and state funding<sup>1,2</sup>; 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 ADHD<sup>3-5</sup>; 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<sup>3,6-8</sup>; 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 neglect<sup>9</sup>; 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 adversity<sup>10</sup>; and  
22

23 Whereas, Children who participate in early childhood education have higher kindergarten scores  
24 in reading, mathematics, cognitive flexibility, and approaches to learning<sup>11</sup>; 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 16<sup>12</sup>; 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<sup>3,13-15</sup>; 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 Germany<sup>16-17</sup>; 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 six<sup>18</sup>; 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 six<sup>19</sup>;  
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 2016<sup>20</sup>; 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%<sup>21</sup>; 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 families<sup>11</sup>; 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 2016<sup>22</sup>; 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 Research<sup>1</sup>; 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<sup>23,24</sup>; 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”<sup>25</sup>; 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

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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/3l51ySj>; 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](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

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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](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

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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.
2. Rogers MS, McNeil DE, Binder RL. Effectiveness of Police Crisis Intervention Training Programs. J Am Acad Psychiatry Law. 2019 Dec;47(4):414-421. doi: 10.29158/JAAPL.003863-19. Epub 2019 Sep 24. PMID: 31551327.
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](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

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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](http://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

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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

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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

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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)<sup>1</sup>; 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 behaviors<sup>1</sup>; 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 actions<sup>1</sup>; 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)<sup>2</sup>; and  
18

19 Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of  
20 2014<sup>3</sup>; 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<sup>1,3,4</sup>; 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 landlords<sup>1</sup>; 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 nuisance<sup>5</sup>; 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 standards<sup>1</sup>; 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 emergencies<sup>5</sup>; 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<sup>2,6,7</sup>; 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<sup>8,9</sup>; 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"<sup>8</sup>; 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<sup>3,10-13</sup>; 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<sup>10,14</sup>; 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 abusers<sup>11</sup>; 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 help<sup>15</sup>; and  
38

39 Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing  
40 nuisance activity are limited<sup>7,12,14</sup>; 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 behavior<sup>12</sup>; 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 eviction<sup>16-18</sup>; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred<sup>13</sup>; therefore be it

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

RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of 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://lawcommons.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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6. HOPE Fair Housing Center v. City of Peoria, IL, 1:17-cv-01360-JBM-JEH (C.D. Ill. filed Aug. 10, 2017).
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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

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Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;<sup>1</sup> and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;<sup>2,3</sup> and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;<sup>4</sup> and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;<sup>5</sup> and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of sexually-transmitted infections (STIs);<sup>5-7</sup> and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;<sup>3</sup> and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency<sup>8</sup>; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;<sup>9</sup> and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;<sup>9</sup> and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than 5% of LGBT students had health classes that included positive representations of LGBT-related topics, and among Millennials surveyed in 2015, only 12% said their sex education classes covered same-sex relationships;<sup>2,9,10</sup> 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);<sup>11</sup> 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;<sup>3</sup> and  
7

8 Whereas, In 2010, the federal government redirected funds from abstinence-only programs to  
9 evidence-based teen pregnancy prevention programs;<sup>12</sup> 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;<sup>2,13</sup> 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;<sup>14</sup> 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;<sup>15</sup>  
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;<sup>11</sup> 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;<sup>16,17</sup> 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;<sup>18</sup> and  
32

33 Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher  
34 than many other industrialized countries;<sup>19-21</sup> 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 births<sup>22</sup>; 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;<sup>23-25</sup> 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;<sup>23,26-28</sup> and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including the Personal Responsibility Education Program (PREP), a state-grant program from the federal government that funds comprehensive sex education;<sup>29,30</sup> and

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

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;<sup>30</sup> and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine's (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;<sup>31-33</sup> and

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

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

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

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

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

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



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

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1 Whereas, The COVID-19 pandemic has shown the ability to shelter in place as a social  
2 determinant of health<sup>1</sup>, and the reduction of homelessness should be a major focus of public  
3 health efforts within the United States<sup>2</sup>; 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<sup>2,3</sup>; and  
8

9 Whereas, Homeless shelters and encampments are particularly susceptible to large outbreaks  
10 of SARS-CoV2<sup>2</sup>, and the crowding in informal settlements make self-quarantine nearly  
11 impossible leading to increase likelihood of rapid infection spread<sup>4</sup>; 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 issue<sup>3</sup>; and  
16

17 Whereas, Implementing housing-first interventions for homeless persons improves their quality  
18 of life while also reducing ineffective public service spending<sup>5</sup>; 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 enrollee<sup>6</sup>, and the homelessness is  
22 linked to greater usage of acute hospital services<sup>5</sup>; 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 homelessness<sup>5</sup>; 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:

- 1 Coughlin CG, Sandel M, Stewart AM. Homelessness, Children, and COVID-19: A Looming Crisis. *Pediatrics*. 2020;146(2):e20201408. doi:10.1542/peds.2020-1408
2. Baggett TP, Racine MW, Lewis E, De Las Nueces D, O'Connell JJ, Bock B, Gaeta JM. Addressing COVID-19 Among People Experiencing Homelessness: Description, Adaptation, and Early Findings of a Multiagency Response in Boston. *Public Health Rep*. 2020 Jul/Aug;135(4):435-441. doi: 10.1177/0033354920936227. Epub 2020 Jun 9. PMID: 32516035; PMCID: PMC7383767.
3. Perri M, Dosani N, Hwang SW. COVID-19 and people experiencing homelessness: challenges and mitigation strategies. *CMAJ*. 2020;192(26):E716-E719. doi:10.1503/cmaj.200834
4. Corburn J, Vlahov D, Mberu B, Riley L, Caiaffa WT, Rashid SF, Ko A, Patel S, Jukur S, Martínez-Herrera E, Jayasinghe S, Agarwal S, Nguendo-Yongsi B, Weru J, Ouma S, Edmundo K, Oni T, Ayad H. Slum Health: Arresting COVID-19 and Improving Well-Being in Urban Informal Settlements. *J Urban Health*. 2020 Jun;97(3):348-357. doi: 10.1007/s11524-020-00438-6. Erratum in: *J Urban Health*. 2021 Apr;98(2):309-310. PMID: 32333243; PMCID: PMC7182092.
5. Stafford A, Wood L. Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants. *Int J Environ Res Public Health*. 2017 Dec 8;14(12):1535. doi: 10.3390/ijerph14121535. PMID: 29292758; PMCID: PMC5750953.
6. Koh KA, Racine M, Gaeta JM, Goldie J, Martin DP, Bock B, Takach M, O'Connell JJ, Song Z. Health Care Spending And Use Among People Experiencing Unstable Housing In The Era Of Accountable Care Organizations. *Health Aff (Millwood)*. 2020 Feb;39(2):214-223. doi: 10.1377/hlthaff.2019.00687. PMID: 32011951; PMCID: PMC7384249.

## 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

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Whereas, Obesity has been recognized by our AMA as a disease<sup>1</sup>; and

Whereas, Obesity is preventable and effective treatments are available; and

Whereas, A top strategic objective of our AMA is to improve health outcomes with regards to type two diabetes and hypertension;<sup>2</sup> and

Whereas, Obesity rates continue to increase and obesity (BMI 30 or more) currently affects 40% of Americans and overweight/pre-obesity (BMI 25 - 29.9) affects 32% of Americans<sup>3</sup>; and

Whereas, Obesity is currently estimated to kill 320,000 Americans and cost 1.72 trillion dollars (9.3% of GDP) per year<sup>4</sup>; and

Whereas, People with obesity are at a higher risk for suffering severe complications from COVID-19 including ICU admissions, mechanical ventilation and death<sup>5</sup>; and

Whereas, "The prevalence of adult obesity and severe obesity will continue to increase nationwide, with large disparities across states and demographic subgroups;"<sup>6</sup> and

Whereas, Obesity rates in children ages 2-19 continue to increase and obesity is currently estimated to affect 19% of children<sup>7</sup>; and

Whereas, The Framingham Heart Study estimated that excess body weight (including overweight and obesity), accounted for approximately 26 percent of cases of hypertension in men and 28 percent in women, and for approximately 23 percent of cases of coronary heart disease in men and 15 percent in women<sup>8</sup>; and

Whereas, While the Affordable Care Act requires payment of preventive health care services rated by the United States Preventive Task Force Services (USPSTF) with an "A" or "B" recommendation, and the USPSTF recommends obesity screening and counseling services

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<sup>1</sup> AMA policy H-440.842

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

<sup>3</sup> 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.

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

<sup>5</sup> 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.

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

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

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

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

Whereas, Obesity disproportionately affects women and minorities<sup>11,12,13</sup>; and

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

Whereas, In a nationally representative sample of US adults, the prevalence of diabetes increases with increasing weight classes. Nearly one fourth of adults with diabetes have poor glycemic control and nearly half of adults with diabetes have obesity, suggesting that weight loss is an important intervention to reduce the impact of diabetes on the health care system<sup>16</sup>; and

Whereas, It is estimated that the prevalence of diabetes will increase by 54% to more than 54.9 million Americans between 2015 and 2030; annual deaths attributed to diabetes will climb by 38% to 385,800; and total annual medical and societal costs related to diabetes will increase 53% to more than \$622 billion by 2030<sup>17</sup>; and

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

Whereas, In spite of AMA policy calling on our AMA to 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), coverage of these services remains

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

<sup>10</sup> Resolution 814, i16 – H-185.925

<sup>11</sup> CDC, [http://www.cdc.gov/nchs/data/hestat/obesity\\_adult\\_11\\_12/obesity\\_adult\\_11\\_12.htm](http://www.cdc.gov/nchs/data/hestat/obesity_adult_11_12/obesity_adult_11_12.htm) accessed 11/14/2016

<sup>12</sup> [https://www.cdc.gov/pod/issues/2019/18\\_0579.htm](https://www.cdc.gov/pod/issues/2019/18_0579.htm) accessed 3/10/2022

<sup>13</sup> 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

<sup>14</sup> 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.

<sup>15</sup> 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

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

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

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

inconsistent, with Medicare still not allowing payment for behavioral treatment outside of the primary care setting, or for anti-obesity pharmacotherapy<sup>19</sup>; and

Whereas, While 85% of individuals affected by type 2 diabetes receive pharmacotherapy, only ~2% receive obesity pharmacotherapy<sup>20</sup> and only ~1% receive metabolic and bariatric surgery<sup>21</sup>, both modalities that can improve health outcomes including prediabetes, diabetes and hypertension and deserve a broader multi-stakeholder strategy; and

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

Whereas, A recent AMA report found that obesity education remains inadequate at medical school and residency programs<sup>25</sup>; and

Whereas, “Low levels of emotional rapport in primary care visits with patients with overweight and obesity may weaken the patient-physician relationship, diminish patients’ adherence to recommendations, and decrease the effectiveness of behavior change counseling,” leading to increases in physician burnout<sup>26</sup>; and

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

Whereas, In spite of the numerous policies our AMA has adopted regarding obesity, education remains sparse<sup>27</sup>, coverage for evidence-based services remains inconsistent, and current efforts at prevention and treatment remain largely ineffective; and

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

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

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

<sup>19</sup> Policy D-440.954, AMA a18

<sup>20</sup> Thomas CE, Mauer EA, Shukla AP, Rath 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.

<sup>21</sup> <https://www.asmb.org>

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

<sup>23</sup> NHLBI. 2012. [www.nhlbi.gov/health/health-topics/topics/obe/causes#](http://www.nhlbi.gov/health/health-topics/topics/obe/causes#). Accessed May 23rd, 2017.

<sup>24</sup> Schwartz MW et al. *Diabetes*. 2003;52:232-238.

<sup>25</sup> CME report 3, AMA a-17

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

<sup>27</sup> 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

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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

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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)

## REFERENCES

<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

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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](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/pmc/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.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](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](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

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1 Whereas, Individuals with mental health illnesses are overrepresented in the criminal justice  
2 system<sup>1</sup>; and  
3

4 Whereas, Researchers estimate that 7-10% of all police interactions involve mental health crisis  
5 assistance<sup>2</sup>; 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<sup>3,4</sup>; 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 students<sup>5</sup>; 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 system<sup>6</sup>; 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 department<sup>3</sup>;  
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<sup>4,7,8</sup>; 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<sup>4,9,10</sup>; 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

#### References:

1. Watson AC, Wood JD. Everyday police work during mental health encounters: A study of call resolutions in Chicago and their implications for diversion. *Behav Sci Law*. 2017;35(5-6):442-455. doi:10.1002/bsl.2324
2. Livingston JD. Contact Between Police and People With Mental Disorders: A Review of Rates. *Psychiatr Serv Wash DC*. 2016;67(8):850-857. doi:10.1176/appi.ps.201500312
3. Law Enforcement Response to Mental Health Crisis Incidents: A Survey of Illinois Police and Sheriff's Departments | ICJIA Research Hub. Accessed November 15, 2020. <https://icjia.illinois.gov/researchhub/articles/law-enforcement-response-to-mental-health-crisis-incidents-a-survey-of-illinois-police-and-sheriff-s-departments>
4. Puntis S, Perfect D, Kirubarajan A, et al. A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry*. 2018;18(1):256. doi:10.1186/s12888-018-1836-2
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7. Jenkins O, Dye S, Obeng-Asare F, Nguyen N, Wright N. Police liaison and section 136: Comparison of two different approaches. *BJPsych Bull*. 2017;41(2):76-82. doi:10.1192/pb.bp.115.052977
8. McKenna B, Furness T, Oakes J, Brown S. Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *Int J Ment Health Nurs*. 2015;24(5):386-393. doi:10.1111/inm.12140
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10. Scott RL. Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatr Serv Wash DC*. 2000;51(9):1153-1156. doi:10.1176/appi.ps.51.9.1153

## 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)